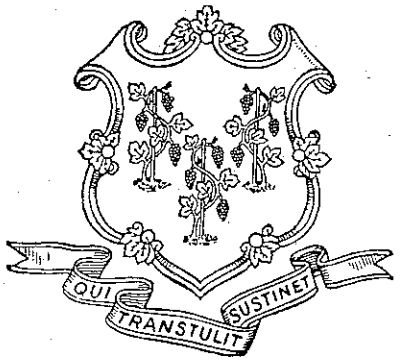
STATE SUBSTANCE ABUSE POLICIES FOR JUVENILES AND YOUTH

Connecticut

General Assembly



LEGISLATIVE
PROGRAM REVIEW
AND
INVESTIGATIONS
COMMITTEE

December 1996

CONNECTICUT GENERAL ASSEMBLY
LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE

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LEGISLATIVE PROGRAM REVIEW
& INVESTIGATIONS COMMITTEE

State Substance Abuse Policies For Juveniles and Youth

JANUARY 1997

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STATE SUBSTANCE ABUSE POLICIES FOR JUVENILES AND YOUTH

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Key Points of Chapter I

Overview of Issues

- Use of illegal drugs and controlled substances are viewed as acts both deserving punishment and needing treatment.
- Drug use is tied to many social problems but, most commonly, it is linked to criminal activity.
- Among the alarming issues associated with substance abuse is the particular concern for children who use drugs and are involved in delinquent or violent activity.
- Juvenile addiction is a progressive process that can be divided into five stages: experiemental use; social use; instrumental use; habitual use; and compulsive use.
- There is no single cause for juvenile delinquency or drug use; children involved in these behaviors often have various social and psychological problems in their backgrounds.

Chapter One

OVERVIEW OF ISSUES

Abuse of alcohol and illegal drugs has been a major public health and safety concern for Connecticut and the United States for the past 40 years. During this period, the use and abuse of illegal drugs and controlled substances have been viewed acts both deserving punishment and needing treatment. As such, substance abuse has been tied, as either a cause or result, to many social concerns and problems. Most commonly, the use of drugs is linked to criminal activity.

The link between drug use and crime is threefold: systemic; economic; and pharmacological. First, systemic crimes include those committed as part of the regular means of doing business in the drug industry, such as the manufacturing, distribution, and sale of drugs. Because the sale and distribution of drugs is an illegal activity, society's normal methods of addressing business disputes, such as the courts and government regulation, are not available. Furthermore, most illicit drugs are expensive and in great demand. Thus, sellers sometimes resort to extreme and violent measures to protect their profitable investment and to settle disputes. Guns are an accepted tool of the illicit drug business. Second, people addicted to drugs need money to support their use. A percentage of these addicts resort to criminal activity, typically robbery, shoplifting, burglary, prostitution, and sale of drugs to obtain money for their habits. Finally, certain drugs or substances act on the central nervous system in such a way as to decrease inhibitions or to increase violent or aggressive behavior in some persons. Cocaine, phencyclidine (PCP), and particularly alcohol appear to be factors in an overwhelming number of violent crimes.

Among the alarming issues associated with substance abuse is the particular concern for children who use and abuse alcohol and drugs and are involved in delinquent or violent activity. During adolescence, some young people become involved with alcohol and other drugs for a variety of reasons, the least of which is that problem behavior and substance abuse are simply signs of normal and rebellious teen-age behavior. Various adolescent problem behaviors are interrelated and include school failure, delinquent and criminal activity, sexual activity, family problems, aggression, anxiety, or depression, and alcohol and other drug use. Most of these problems result from the child's environment and experiences and not from anything inherent in adolescence.

Juvenile Addiction Process

Juvenile addiction is a progressive process that can be divided into five stages: experimental use; social use; instrumental use; habitual use; and compulsive use. While the stages of use have been defined through research and treatment, the practical borders that separate them are not as sharply defined. As one researcher notes, "addicted adolescents are a mass of contradiction"[1] -- not easily categorized but sharing the gradual and continued use of drugs that leads to addiction.

Experimental use. Curiosity about the effects of drugs, risk-taking, and peer pressure are the primary motives for the experimental use of alcohol and drugs. Children and teen-agers are more interested in the adventure of drug use then the mood-altering effects of the chemicals. At this stage, frequency of use is occasional and may occur alone or in social situations.

Many adolescents experiment with substance use and do not progress to the next stages of addiction. It is children who are at risk because of other negative factors in their lives, such as drug-using parents or adult role models, who continue to use illegal drugs and alcohol.

Social use. Drug and alcohol use at this stage is strictly social, taking place at parties, in parking lots, or other gatherings. Social acceptance is the primary motivation but curiosity, risk-taking, and defiance also play a part in the process. Adolescents and young adults may use drugs or drink excessively to "fit in with the crowd," and the illegal substances are shared or sold among friends.

During this phase, the adolescent's motives are not much different from adult motives in that substance use serves to ease the child in social situations. Drugs and alcohol are used to "loosen up" at parties or gatherings where they are socially accepted and promoted. It is at this stage that young people experience the impact drugs and alcohol have on their emotions and behavior. However, since they feel normal after use and remain functional, substance use is not considered risky by them. The warning signs of addiction, such as absences from school, dropping grades, and problems with friends and family members, are typically ignored at this stage.

Instrumental use. "In the instrumental stage, the adolescent learns, through a combination of trial-and-error experience and modeling, to use substances purposefully to manipulate emotions and behavior."[2] They discover drugs and alcohol affect both feelings and actions and, moving beyond social use, they actively seek out the specific effects of the

[1]Joseph Nowinski, *Substance Abuse in Adolescents and Young Adults* (Norton Press, 1990), pp 38

[2]Ibid, pp 41

substances. It is important to note that at the instrumental stage, the user continues to feel normal after getting high or drunk and, except for the occasional hangover, there is little discomfort or withdrawal. Behavioral and personality changes may begin at this point: school grades drop; absences from class increase; motivation for school and other activities decrease; conflict with parents and siblings intensifies; and there is resistance and rebellion against house and school rules.

There are two types of instrumental use: hedonistic and compensatory. Hedonistic use of drugs is simply for the pleasure of the effect, and is characterized by experimentation with various substances and binging. The second is compensatory use in which the adolescent intentionally uses drugs and alcohol as a way to cope with stress and suppress feelings such as anger, anxiety, shame, guilt, loneliness, and boredom. The use of drugs and alcohol that starts out as fun at social events evolves into a means of coping.

Habitual use. The fourth stage differs from the others in that the frequency of use increases and the symptoms of dependency on the drugs or alcohol start to appear. The substance *user* becomes an *abuser*, in treatment parlance, and his or her lifestyle becomes progressively centered around drugs or alcohol. Obtaining and using drugs or alcohol are top priorities and the individual's peer group shifts from old friends to people who are also heavy users. The teen-ager's clothing, language, interests, and attitudes change to conform to the new peer group.

During the habitual stage, the user does not return to a normal emotional or physical state after using drugs or alcohol, even after the hangover passes, and the first signs of withdrawal occur. The user begins to feel irritable, restless, or even depressed when not high and can find it difficult to sleep or sit still. Substances are used on a more regular basis, in larger quantities, and new drugs are tried to alleviate the withdrawal symptoms. "Habitual users begin to crave their drug(s) of choice and become preoccupied with getting high."[3]

There are two occurrences during the habitual stage that drive the user toward addiction. First, withdrawal symptoms appear and the user craves drugs or alcohol. The teen-ager uses the drugs to medicate these feelings. Second, the user's drug tolerance changes. Increased quantities of the substances are needed to produce the desired effect. The user is motivated to use more of the same drug, a stronger form of the drug, or a new substance to get high.

Compulsive user. In this final stage, the substance *abuser* becomes the *addict* and drug use is a compulsive behavior that is out of the user's control. Tolerance is lessened, thus requiring more and more drugs and being high becomes the normal state. Anything less and the withdrawal symptoms create discomfort for the addict.

[3]Ibid, pp 48

One of the most noticeable personality changes is that the adolescent becomes self-centered. School, work, hobbies, and other interests are ignored while the focus of the addict's lifestyle is drugs or alcohol. Relationships with parents, friends, teachers, and others are neglected and result in alienation, and the addict learns to manipulate those around him or her. At this stage, addicted adolescents are preoccupied with obtaining drugs and they will go to great lengths to maintain their sources. For example, girls might become the girlfriends of dealers and boys and girls may begin to sell drugs and commit crimes to make money to guarantee their own supply.

Juvenile Delinquency and Violence

Delinquency. Like substance abuse, there is no single cause of juvenile delinquency. Juvenile delinquents, especially those involved in chronic and repeated misbehavior, often have various social and psychological problems in their backgrounds. These problems, called risk factors, are the result of breakdowns in the five major areas of a child's life: family; school; peers; neighborhood; and individual characteristics. Risk factors that make children more prone to delinquency include: poor parental monitoring and inconsistent disciplinary practices; parents' or peers' involvement in drugs or crime; family life filled with violence, child abuse, or neglect; community disorganization; availability of drugs and firearms; persistent poverty; and a lack of housing, educational, and employment opportunities.

Although there are many risk factors that cause a child to become involved in delinquency and violence, research by the federal Coordinating Council on Juvenile Justice and Delinquency Prevention found those shown in Table I-1 to be the most common. The council further found that young people with a combination of several risk factors in their lives were more likely to be delinquent.

The risk factors for delinquency often exist simultaneously and exacerbate one another making them more difficult to control. Delinquent behavior ranges from minor violations to serious felonies. However, "most arrested juveniles, whether male or female, have not committed serious or violent crimes, but rather property crimes or status offenses."[4] (Status offenses are acts that if committed by an adult would not be crimes, for example, truancy or curfew violations.)

Violence. Violent behavior is serious and extreme conduct that is intended to or does cause harm or injury to another person. While most violent behavior is learned, nearly everyone has some potential for violence, but most have effective, non-violent ways of resolving issues or achieving their purposes. Unfortunately, for some youth, violence is either the only or the most effective way to achieve status, respect, or other social and personal needs.

[4]Coordinating Council on Juvenile Justice and Delinquency Prevention, *Combating Violence and Delinquency*, (March 1996), pp 5

Table I-1. Risk Factors for Juvenile Health and Behavior Problems

Adolescent Problem Behaviors	Substance Abuse	Delinquency	Violence
Community Risk Factors			
Availability of drugs	✓		
Availability of firearms		✓	✓
Transitions & mobility	✓	✓	
Low neighborhood attachment & community organization	✓	✓	✓
Extreme economic deprivation	✓	✓	✓
Family Risk Factors			
Family history of the problem behavior	✓	✓	
Family management problems & family conflict	✓	✓	✓
Favorable parental attitudes & involvement in the problem behavior	✓	✓	✓
School Risk Factors			
Early & persistent antisocial behavior	✓	✓	✓
Academic failure beginning in elementary school	✓	✓	✓
Lack of commitment to school	✓	✓	
Individual/Peer Risk Factors			
Rebelliousness	✓	✓	
Friends who engage in the problem behavior	✓	✓	✓
Early initiation of the problem behavior	✓	✓	✓

Source of Data: *Combating Violence & Delinquency*, Coordinating Council on Juvenile Justice & Delinquency, 1996 report

Current research states that adolescents who commit violent acts fall into two categories. The first category includes a small portion of the population who commit a general, stable pattern of criminal behavior. The majority, however, fall into the second category in that they are violent for a limited period of time during their adolescence. Teens in this group eventually mature and lessen or stop their involvement in violence. It should be noted that juveniles not only commit the violence but are, in increasing rates, the victims of violence.

There are four types of adolescent violence: situational; relationship; predatory; and psychopathological. Situational violence is related to specific situations in which a catalyst can lead to and increase the seriousness of the act. The violent act is not attributable simply to the adolescent nature or character but rather to factors such as stress, extreme heat, weekends, accident or unavoidable event, the availability of handguns, and alcohol and drug use. The second type, relationship violence, is a result of disputes and fights between family and friends, and characterizes a large portion of adolescent violence. The violence may occur as an unusual incident, or periodically, as a family habit with the occurrence of violence between parents, toward or among the children, or as dating violence. The third type of violence is predatory violence that is perpetrated intentionally for some gain or as part of a pattern of criminal behavior, such as mugging, robbery, and gang assaults. Most research estimates suggest that a small percentage of all adolescents commit predatory violence and an even smaller portion of that group is responsible for most of the violence. Finally, psychopathological violence rarely occurs but is particularly lethal and disturbing. The violence tends to be more repetitive and extreme than the other types and is different in that it is related to neural or psychological trauma to the child (e.g., a child with a psychopathological disorder or one who witnessed a traumatizing event.)

Involvement in drug use and crime are two common features of a deviant juvenile lifestyle. In some cases they are connected and a juvenile's involvement in one can present opportunities to engage in the other. Drug use and crime do reinforce one another, but viewing drug use as a primary cause of crime oversimplifies the relationship. It is important to note that for some individuals drug use is independent of their involvement in crime and they might commit crime even if drugs were unavailable and some young people who use drugs do not commit crime, except for the possession of illegal drugs.

Key Points of Chapter II

Legislative History and Trends

- Connecticut law makes it illegal for persons of any age to *possess or sell* drugs (e.g., cocaine, heroin, and marijuana), but the *use* of drugs is not expressly prohibited.

- It is illegal to sell to or provide a person under 21 (a minor) with alcohol, and the law further makes it an infraction for a minor to possess alcohol and a person under 18 to possess nicotine.

- Connecticut drug laws are not classified as felonies or misdemeanors, and the minimum and mandatory sentences are set out in statute.

- The first significant legislation on the treatment of substance abuse, passed in 1967, authorized treatment services in addition to criminal sanctions.

- Current state substance abuse policy takes a two-pronged approach: punishment and treatment.

- Substance abuse policy is established by law but is also driven by public opinion, existing services, and federal and state funding practices.

Chapter Two

LEGISLATIVE HISTORY AND TRENDS

National Legislative History

Alcohol, tobacco, opium, cannabis, and coca are substances that have been consumed for many hundreds of years. Each has been used for medicinal, ritual, and recreational purposes; perceived as good and bad for both the individual and society; and subjected to government controls, sanctions, taxation, zoning, and regulatory measures. Finally, each has been available in unregulated markets.

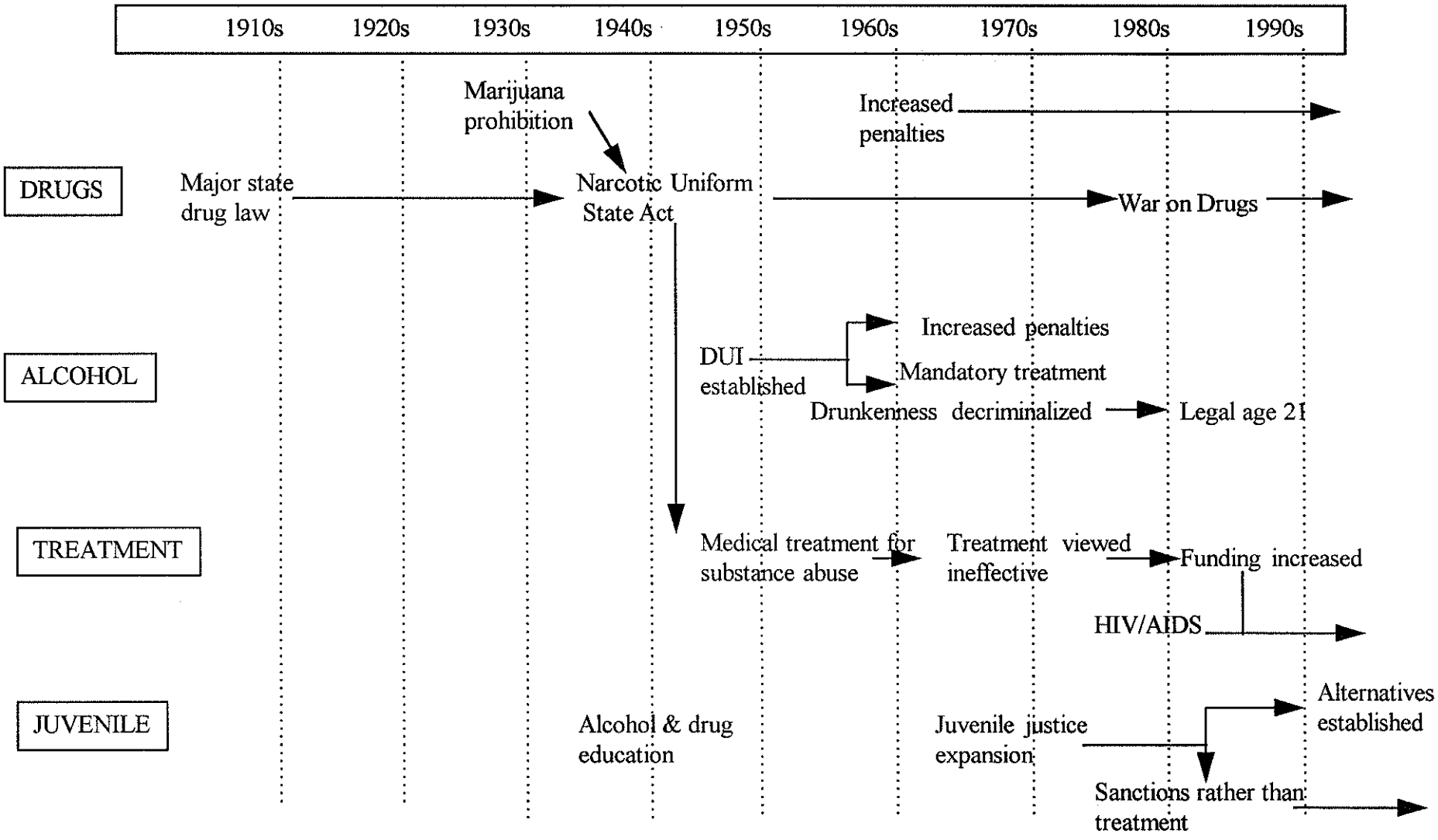
During the late 19th century, many states banned the sale of alcohol while allowing for the legal sale of opiates, cocaine, and cannabis (primarily marijuana and hashish), which were commonly purchased by all social classes for medicinal purposes. At the turn of the 20th century, tobacco smoking was prohibited by 14 states and smoking by women was specifically banned in most places. The first major piece of drug legislation -- the 1906 Federal Pure Food and Drug Act -- required manufacturers to disclose whether their products contained any drugs or alcohol. The quality of non-narcotic drugs improved and, in 1914, a federal ban on opiates and cocaine was enacted after facing little public resistance. Marijuana prohibitions were established in the 1930s, and the alcohol prohibition was repealed in 1933.

The first omnibus federal drug legislation was enacted in 1964. Called the "Drug Abuse Control Amendment," it focused on the distribution and record keeping requirements of prescription drugs like depressants and stimulants. Congress has enacted drug legislation almost every year since, sometimes emphasizing enforcement and sometimes rehabilitation. Most governments, including the United States, signed the international drug prohibition conventions of 1961, 1971, and 1988.

Connecticut Legislative History

Much legislation over the past couple decades has influenced the character of Connecticut's current laws regarding drugs, youth, and alcohol. The time line in Figure II-1 highlights important legislative changes surrounding the issue of drug use and abuse. The legislative changes are examined chronologically within the following five categories: drugs; alcohol; treatment; juveniles; and education.

Figure II-1. Legislative History Timeline for Drug and Alcohol Controls.



Chronology of drug legislation. As far back as 1882, Connecticut enacted a law regulating the sale of certain drugs and narcotics. The law specified legal sellers to be physicians, pharmacists, and veterinarians, and also made it illegal to taint or dilute any substance without notice to the buyer. Persons violating this law were subject to a fine of $25 to $50.

Four years after the federal ban on narcotics (1918), Connecticut enacted its first comprehensive legislation on narcotic drugs that prohibited the sale and possession of cocaine, opium, morphine, heroin, codeine, and other derivatives. Only licensed physicians, dentists, and veterinarians were allowed to prescribe the drugs, but there were restrictions. A prescription could be issued only once and could not be given to patients known to be "habitual user(s)...except when such drug is obviously needed for therapeutic purposes." The statutory penalties for illegal sale of narcotic drugs was a $1,000 fine or one year imprisonment or both, while illegal possession, by anyone other than a licensed medical professional, was subject to a $100 fine or 60 days imprisonment or both. Under this law, however, small amounts of opium, morphine, heroin, codeine, and cocaine were still legal in over-the-counter medicines.

Again following national prohibitions on drugs, a 1939 revision of the state's drug laws included cannabis (e.g., marijuana and hashish) as an illegal substance. In 1949, the Uniform State Narcotic Drug Act was enacted. The emphasis of this bill was similar to past legislation in that narcotic drugs, such as morphine, codeine, heroin, cocaine, and opium, were illegal to possess unless prescribed by a licensed physician, pharmacist, dentist, veterinarian, and small amounts of these drugs remained legal. However, the penalties for a violation of the law were increased to a $2,000 fine and up to five years' imprisonment or both.

The next major piece of drug legislation was passed in 1967 and was the precursor to the state's current drug laws. The legislation did several things. First, the law relating to the sale and possession of drugs and graduated sanctions for first and second offenses was established. Secondly, drug abuse and drug dependency were defined. The third aspect was the creation of a drug advisory council to study the drug laws, drug trafficking, and treatment of substance abuse. Finally, the legislature took a two-pronged approach to drug addiction by mandating criminal sanction and treatment.

In contrast to the increase in penalties for drug offenses, a felony criminal prosecution or sentence for a drug conviction could be suspended if the offender was found to be drug-dependent. A period of probation was imposed and treatment services provided by the Department of Mental Health.

Throughout the 1970s and 1980s, the legislature continued to increase the criminal penalties for sale and possession based on the types and amounts of illegal drugs and stiff

criminal penalties for the sale of drugs by a *non-dependent* offender were established. Previously, the law had not distinguished between illegal drugs sold by the addicted versus non-addicted offender.

In 1980, the use, possession with intent to use, or delivery of drug paraphernalia knowing that it will be used with controlled drugs was categorized as a class C misdemeanor punishable by one to 10 years imprisonment. Previously, possession of drug paraphernalia was only subject to a maximum fine of $100.

In 1989, major drug-oriented legislation addressing both criminal sanctions and treatment was enacted. The new law appropriated funds for a variety of new and existing drug enforcement and treatment programs; increased penalties for adults who use children to sell drugs; and expanded the state's authority to seize property in criminal drug cases. A boot-camp program for convicted 16- to 21-year-old males as an alternative to incarceration and a treatment facility for female offenders were also established. The law further authorized the court to order a drug-dependant defendant to submit to random testing and participate in treatment as conditions of bail. Finally, mandatory prison terms were increased for the sale or possession of drugs or paraphernalia on or near school grounds, day care centers, and public housing projects.

Current drug laws. Existing law makes it illegal for persons of any age to possess, sell, distribute, manufacture, or transport controlled substances and narcotic or hallucinogenic drugs, the most common of which are heroin, cocaine, and marijuana. However, the *use* of a controlled drug (e.g., cocaine, crack, heroin, LSD, marijuana, etc...) or substance is not expressly prohibited. Sanctions or penalties imposed for violation of the drug laws include incarceration, fines, alternatives to incarceration, and mandatory treatment programs.

The laws are contained in Chapter 420b of Title 21a of the Connecticut General Statutes, relating to consumer protection, and are based on the federal Controlled Substances Act (21 USC 801 *et seq.*). Although the laws specify criminal sanctions, such as imprisonment and fines, they are not part of the penal code, the state's criminal law.

Drug abuse is defined by law as the use of controlled substances solely for their stimulant, depressant, or hallucinogenic effect and not as therapy prescribed for medical treatment. Drug dependency is statutorily defined as "a state of physical or psychic dependence, or both, upon a controlled substance" through repeated periodic or continuous use. A person cannot be considered drug-dependent as a result of prescribed medical treatment. An intoxicated person is one whose mental or physical functioning is substantially impaired as a result of the use of alcohol or drug. A person incapacitated by alcohol or drugs has such impaired judgment that he or she cannot make rational decisions regarding the need for treatment.

Controlled drugs are statutorily defined as those: (1) containing any quantity of a substance listed in the federal Controlled Substance Act; (2) designated as a depressant or stimulant drug pursuant to federal food and drug laws; or (3) designated by the state commissioner of consumer protection as having a stimulant, depressant, or hallucinogenic effect and a tendency to promote abuse or dependency. The drugs are statutorily classified as amphetamine, barbiturate, cocaine, cannabis, hallucinogenic, morphine, or stimulant and depressant types. Narcotic substances include morphine, opium, opiates, cocaine, coca and salts, and derivatives having similar physiological effects and potential for abuse. Possession and sale of narcotics is illegal when those activities occur outside of the legitimate medical and pharmaceutical use and distribution system. The statutes specifically exclude alcohol, nicotine, and caffeine as controlled drugs. However, state law also makes it illegal to sell or provide alcohol to persons under 21 (a minor) and makes possession of nicotine by persons under 18 and of alcohol by minors infractions.

Statutory penalties for drug offenses are based on four factors: (1) type of drug; (2) amount of drug; (3) offender's prior criminal history regarding drug offenses; and (4) whether the offender is drug dependent. Table II-1 lists the laws prohibiting the sale of drugs, the penalties, and any exceptions to the penalties, and Table II-2 describes the possession-of-drugs laws. As shown, the most serious offense, a capital felony, is the sale of heroin, cocaine, or methadone that directly causes a person's death, and is punishable by life imprisonment without the possibility of early release, or a death sentence.

The penalties for the sale of drugs by a non-drug dependent person are more stringent and impose mandatory minimum terms of incarceration. The mandatory minimums may only be reduced or waived for offenders under the age of 18 years or if medical treatment is imposed.

In addition, the statutes require a mandatory prison sentence for any drug offense committed within 1,500 feet of an elementary or secondary school, day care center, or public housing project. The mandatory sentences are consecutive to any other sentence imposed for conviction of a drug or felony offense. A consecutive sentence begins after the completion of the controlling (primary) sentence; the two sentences may not be served concurrently.

As shown in the tables, only three drug offenses have been classified based on the system used in the penal code, which categorizes crimes as A, B, C, or D felonies or misdemeanors. An A felony is the most serious for sentencing purposes. The misrepresentation of a substance as an illegal drug is a class D felony punishable by a prison term not less than one year nor more than five years; the sale of drug paraphernalia is a class A misdemeanor punishable by jail term not to exceed one year; and the possession or use of drug paraphernalia is a class C misdemeanor punishable by a jail term not to exceed three months. All other drug offenses are unclassified in statute and have specific sentencing guidelines.

Table II-1. Connecticut Statutes Prohibiting Drug Sale						
C.G.S. cite	*Offense Description*	*Statutory Penalties*	*Statutory Exceptions*	*Pre-Trial Diversion*		
				*AR**	*CSLP**	*Treatment*
53a-54b(6)	Sale of heroin, cocaine, or methadone directly causing the user's death: capital felony	Life imprisonment without possibility of early release or death sentence if jury finds that aggravating factors outweigh mitigating factors (53a-46a)		Yes	No	No
21a-278(a)	Sale by a nonaddict of at least 1 oz. of heroin, cocaine, or methadone; 5 mg. of LSD; or .5 g. of crack	Mandatory minimum 5- to 20-year prison term, possible maximum term of life imprisonment	Youth or mental impairment: sentence may be reduced below mandatory minimum	Yes	No	No
21a-278(b)	Sale by a nonaddict of at least 1kg. of marijuana, or any amount of narcotics, amphetamines, or other hallucinogens	Minimum 5-year prison term up to a 20-year maximum. Subsequent offenses: mandatory minimum 10-year prison term up to a 25-year maximum	Youth or mental impairment: sentence may be reduced below mandatory minimum	Yes No	No No	No No
21a-278a(b)	Sale of illegal drug by nonaddict within 1,500 feet of an elementary or secondary school, a licensed day care center, or public housing project	Mandatory 3-year prison term running consecutively to prison term imposed for violating any other drug sale law		Yes	No	No
21a-278a(a)	Sale of illegal drug to minor by nonaddicted adult at least 2 years older than minor	Mandatory 2-year prison term running consecutively to prison term imposed for violating any other drug sale law		Yes	No	No
21a-278a(c)	Hiring minor to sell illegal drug in violation of 21a-277 or 21a-278 as described above	Mandatory 3-year prison term running consecutively to jail term imposed for violating any other drug sale law		Yes	No	No

Table II-1. Connecticut Statutes Prohibiting Drug Sale						
C.G.S. cite	*Offense Description*	*Statutory Penalties*	*Statutory Exceptions*	*Pre-Trial Diversion*		
				*AR**	*CSLP**	*Treatment*
21a-277(a)	Sale of any narcotics or hallucinogens other than marijuana	First offense: up to 15-year prison term, up to a $50,000 fine, or both		Yes	No	Yes
		Second offense: up to 30-year prison term, up to a $100,000 fine, or both		No	No	No
		Subsequent offenses: up to 30-year prison term, up to a $250,000 fine, or both		No	No	Yes
		Alternative sentence: up to 3-year indeterminate jail term with conditional release by correction commissioner 21a-277(d)				
21a-277(b)	Sale of any other illegal drug	First offense: up to 7-year prison term, up to a $25,000 fine, or both		Yes	No	Yes
		Subsequent offenses: up to 15-year prison term, up to a $100,000 fine, or both		No	No	Yes
		Alternative sentence: up to 3-year indeterminate prison term with conditional release by correction commissioner 21a-277(d)				
21a-268	Misrepresentation of substance as an illegal drug	Up to 5-year prison term, up to a $5,000 fine, or both				

*AR = accelerated rehabilitation CSLP = community service labor program
Source of Data: Connecticut General Statutes and OLR report 95-R-1332

Table II-2. Connecticut Statutes Prohibiting Drug Possession						
C.G.S.	*Offense Description*	*Statutory Penalties*	*Other*	*Pre-Trial Diversion*		
				*AR**	*CSLP**	*Treatment*
21a-279(a)	Illegal possession of narcotics (i.e., heroin, cocaine, crack)	First offense: up to 7-year prison term, up to a $50,000 fine, or both		Yes	Yes	Yes
		Second offense: up to 15-year prison term, up to a $100,000 fine, or both		No	Yes	Yes
		Subsequent offenses: up to 25-year prison term, up to a $250,000 fine, or both		No	No	yes
		Alternative sentence: up to 3-year indeterminate prison term with conditional release by correction commissioner 21a-279(e)				
21a-279(b)	Illegal possession of dangerous hallucinogens or at least 4 oz. of marijuana	First offense: up to 5-year prison term, up to a $2,000 fine, or both		Yes	Yes	Yes
		Subsequent offenses: up to 10-year prison term, up to a $5,000 fine, or both		No	Yes	Yes
		Alternative sentence: up to 3-year indeterminate prison term with conditional release by correction commissioner 21a-279(e)				

Table II-2. Connecticut Statutes Prohibiting Drug Possession						
C.G.S.	*Offense Description*	*Statutory Penalties*	*Other*	*Pre-Trial Diversion*		
				*AR**	*CSLP**	*Treatment*
21a-279(c)	Illegal possession of any other drug or less than 4 oz. of marijuana	First offense: up to 1-year prison term, up to a $1,000 fine, or both Subsequent offenses: up to 5-year prison term, up to a $3,000 fine, or both Alternative sentence: up to 3-year indeterminate prison term with conditional release by correction commissioner 21a-279(e)		Yes	Yes	Yes
21a-279(d)	Possession of illegal drugs by a nonstudent within 1,500 feet of an elementary or secondary school or a licensed day care center	Mandatory 2-year prison sentence running consecutively to prison term imposed for violating any other drug possession laws		Yes	Yes	Yes
21a-267(a)	Possession or use of drug paraphernalia	Up to 3-month jail term, up to $500 fine, or both				
21a-267(b)	Deliver or possess or manufacture with intent to deliver drug paraphernalia	Up to 1-year jail term, up to a $2,000 fine, or both				
21a-267(c)	Possession, use, or delivery of drug paraphernalia within 1,500 feet of an elementary or secondary school by a nonstudent	Additional 1-year mandatory minimum sentence				

* AR = accelerated rehabilitation
CSLP = community service labor program
Source of Data: Connecticut General Statutes and OLR report 95-R-1332

Chronology of alcohol control legislation. During the 1970s, there were significant legislative changes to the way Connecticut had dealt with alcoholics for more than 300 years. In 1974, the General Assembly laid the groundwork for decriminalization of drunkenness and public intoxication, and adopted a treatment policy rather than criminal sanctions. Alcoholism was deemed an illness best dealt with by the state's health care system. The act stressed voluntary commitment through carefully proscribed procedures involving interactions between the health care system and the court system. In 1976, the Uniform Intoxication Act became law, which decriminalized public intoxication.

In 1982, the legal minimum drinking age was raised from 18 to 19 and, one year later, to 20 years. In 1985, the legal minimum was again raised to the current age of 21 years. Subsequent legislation instituted a fine for minors (under 21 years) in public possession of liquor and, to further discourage underage drinking, increased statutory penalties for furnishing alcohol to a minor. A minor is subject to a fine of $200 to $500 for purchasing or possessing alcohol and also to not more than 30 days incarceration for using another person's driver's license to buy liquor.

A 1963 law made it illegal to drive under the influence of alcohol or drugs (DUI). Throughout the past 20 years, the trend in legislation has been to increase the penalties for DUI offenses, especially those resulting in injury or death to another person. The laws focused on testing for blood alcohol level procedures, drivers license suspensions, and the limitations on illegal blood alcohol content (BAC) levels.

An adult, 21 years or older, is considered under the influence of alcohol with a BAC of .10% or more and is impaired with a BAC of between .07% and .10%. While the BAC level for being considered under the influence is the same for minors, a 1995 law established a different impairment standard -- a minor with a BAC of more than .02% but less than .10% is considered impaired.

A pretrial alcohol education program for first-time DUI offenders was established in 1981, allowing the dismissal of criminal charges upon successful completion of the program. The law eliminated the mandatory minimum sentence of two days in jail for repeated DUI convictions and instituted an automatic 90-day suspension of a driving license for individuals who refuse to submit to BAC testing.

Chronology of treatment legislation. The first significant legislation on the treatment of substance abuse was in 1967. As previously discussed, the same legislation that increased criminal sanctions for the sale and possession of illegal drugs also authorized treatment services. The law recognized that the treatment of drug-dependent persons was a medical problem although the control of illicit traffic in drugs was a regulatory problem. It further authorized the Department of Mental Health to approach substance abuse from a medical standpoint by creating

in-patient hospitals and facilities as well as community-based treatment programs and to implement commitment criteria.

In the late 1980s, treatment programs addressing the needs of substance abusers infected with the HIV/AIDS virus were legislatively created. In 1990, the Department of Health Services (DHS) was directed to establish a demonstration needle and syringe exchange program with the Connecticut city with the highest incidence of injecting drug users (IDUs) infected with AIDS.

The program was to be operational by October 1, 1990, and New Haven was selected as the site. The exchange program was eventually expanded to Bridgeport, Danbury, Hartford, Stamford, and Windham. In responding to the needs of the needle program, 1992 legislation decriminalized the sale and possession of hypodermic needles and syringes, in quantities of eight or fewer, without a prescription and amended the definition of drug paraphernalia to exclude needles and syringes in quantities fewer than eight. Most recently, in 1994, the statutory limit on the number of needle exchange programs operating in the state was repealed and the number of needles that can be purchased and possessed was raised to 10.

The commitment criteria and procedures for alcohol- and drug-dependent persons were combined in 1990, and new welfare reform legislation in 1991 required that substance abusers get treatment in order to qualify for general assistance benefits. Legislation, directly affecting young people, allowed minors under the age of 18 years to legally consent to alcohol and drug treatment and, for those charged with delinquency, to request an examination for alcohol or drug dependence. If deemed dependent, the judicial proceeding could be suspended for up to one year while the offender sought treatment. The criminal charge(s) can be dismissed upon successful completion of a program.

Chronology of juvenile legislation. Separate justice systems for adults and juveniles were established during the late 1800s and by 1950 all states had juvenile courts. These courts were non-adversarial in nature, viewing the juvenile offender as a delinquent rather than a criminal. The juvenile court's mission was to provide care and treatment for young offenders whose rehabilitation was considered more important than concern for community protection, retribution, punishment, or deterrence.

Throughout the 1960s and 1970s, juvenile due process and procedures were expanded. Furthermore, the system was deinstitutionalized and children were no longer detained or incarcerated in adult facilities or imprisoned for offenses which would not have been considered criminal if committed by an adult (status offenses). However, by 1980, an increase in juvenile crime coupled with a highly publicized view that efforts at rehabilitation in the juvenile justice system were unsuccessful forced a shift in the law. While not abandoning the rehabilitation approach, punishment was given a comparable role in statute.

Over the next several years additional youth-oriented legislation was enacted. Select crimes were identified as serious juvenile offenses for which a 14- or 15-year-old could be prosecuted as an adult. In 1987, offenses for the sale of illegal drugs were classified as serious juvenile offenses and, in 1989, the mandatory transfer of certain serious juvenile offenders to adult court was repealed. The change gave the court discretionary authority over the transfers.

In 1994, the court was given greater latitude in sentencing youthful offenders through increased penalties and mandatory alcohol or drug treatment. In 1995, significant legislative changes in the juvenile justice system were enacted, including development of alternative sanctions for juveniles, reestablishment of the criteria for mandatory transfer from juvenile to adult court, and increased sanctions for serious juvenile repeat offenders.

In 1994, the legislature authorized school or law enforcement officials to search lockers or other school property for weapons, contraband, or evidence of a crime if there were reasonable grounds for a school official to believe a student had violated either the law or school rules and the search was not "excessively intrusive." In general, school officials have wide discretion in formulating "reasonable" school regulations to maintain order and discipline and to define those offenses for which a student may be suspended or expelled.

There are no state or federal statutes that cover drug testing of students in school. Student testing is subject to the limitations of the Fourth Amendment prohibiting the state from conducting unreasonable searches and seizures, however, students can be required to take random drug tests in certain situations.

The most recent high court ruling on the issue of drug testing of public school students is Vernonia School District 47J v. Acton, 115 S.Ct. 2386 (1995). In that case, the Court upheld a public high school's policy of making periodic, random drug testing of student athletes a condition for participation in school sports. In a previous case, the Court had ruled that a search that is unsupported by probable cause and conducted without a warrant can be constitutional "when special needs, beyond the normal need for law enforcement, make the warrant and probable cause requirement impracticable" (Griffine v. Wisconsin, 483 U.S. 868, 873). In Veronia, the Court ruled that such "special needs" exist in the public school context. The majority based its ruling on three basic points. First, unemancipated minors do not have all the same rights as adults. Schools are allowed to exercise a degree of supervision and control over their students that could not be exercised over free adults. Second, student, and especially student athletes, have a lesser expectation of privacy than members of the general population. Third, the need to discourage drug use among children is compelling enough to justify the type of testing that the school district is engaged in. The current focus in Connecticut schools is on drug possession rather than drug use and the Department of Education discourages districts from testing students.

Education. As far back as 1884, Connecticut mandated that the effects of alcohol and drugs be taught in public schools by licensed teachers. By 1902, it was required that alcohol and drug education begin in the fourth grade and continue up to the high school grades, at which point it was not a curriculum requirement. A 1949 revision required the effect of alcohol and drugs, as well as of nicotine or tobacco, be taught each year to all students in public school grades. In 1978, legislation established a curriculum requirement for substance abuse prevention as part of the health and safety instruction in the public schools, and imposed an annual reporting requirement on schools. Seventeen years later, the legislature removed the power of the state Board of Education to prescribe the content of substance abuse education courses, placing the authority in the local school boards.

In 1993, school boards were mandated to adopt policies and procedures for dealing with students' use, sale, or possession of drugs on school grounds. These policies and procedures include a process for referring students to appropriate agencies and cooperating with law enforcement officials. In 1996, a new requirement for school boards to provide in-service training for teachers and administrators on risk reduction behavior and the nature and relationship of drugs and alcohol to health and personality development was established.

Policy Development

The current state substance policy takes a two-pronged approach to controlling the use of illegal drugs: punishment and treatment. Under the punishment strategy, the state attempts to control the use of drugs by making it illegal to manufacture, sell, and possess drugs and by prosecuting and punishing violators of the drug laws. Criminal penalties are set forth as deterrents to participation in drug trafficking and using. This strategy, which has been implemented on a state and national level, gives the criminal justice system a major role in controlling illegal drug use.

The second policy recognizes substance abuse as a pervasive medical and mental health problem that requires treatment to control or reduce the individual's dependency on drugs or alcohol. Extensive research exists supporting the rationale for providing substance abuse treatment, especially for children and adolescents. The consensus of the national literature is that societal costs of untreated addition far exceed the costs of providing treatment.

Neither punishment nor treatment is expressly favored in statute as the principle course of action; state funding is provided for both. Of course, the policies are not mutually exclusive. For example, treatment is available for criminal offenders and, in some cases, imposed in lieu of prosecution and sanctions. However, state substance abuse policy is not solely based on law, but is also driven by public opinion, existing services, and federal and state funding.

Substance abuse is a wide-ranging problem that has serious social, health, and economic costs and consequences. Since the 1970s, public opinion and perceptions have been intolerant of illegal drug use and crime. The current "zero tolerance" attitude has fueled the punitive measures enacted in recent legislation. They include: making it easier to transfer a juvenile accused of committing a felony from juvenile to adult court; harsher sentencing for serious, repeat juvenile offenders; restricting participation in most of the alternative sentencing programs to first time offenders; and mandatory minimum sentences for repeat drug offenses.

Substance abuse treatment has been a legitimate field of practice and research since the 1960s. Over time, entrenched treatment modalities have become the "best practice" and now guide public policy. However, these long-standing programs and services were not developed based upon coherent strategies and outcome measures. They tended to be immediate responses to particular drug or social problems at a contained point in time. The state has come to rely on a treatment system, developed through historical practices, that does not provide a comprehensive, coordinated approach to remedying the complex problem of substance abuse and its related issues nor does it effectively and efficiently meet the needs of all segments of the state population.

The federal government has been a major contributor to the development of this system. Partly in response to federal initiatives, a substance abuse policy was developed based on services that met the parameters of the grant and funding applications and not the particular needs of the state. Often times the programs were continued with state funding and became the "best practices" of the treatment delivery system.

National Treatment Trends

For the century's first five decades, the control over the use of drugs or alcohol was the sole concern of law enforcement officials. Physicians were reluctant to treat drug addicts because of the 1914 Harrison Act, which imposed criminal sanctions for using or prescribing opiates for anything other than pain control, and drug addicts were either placed in prison or psychiatric facilities for the protection of society. However, during the 1960s, substance abuse treatment developed into a legitimate field of research and practice. Two primary treatment models emerged that remain basically unchanged today: medical and clinical.

The medical model holds that drug addicts can be maintained on a safer surrogate drug. By the late 1960s, this model produced the methadone clinic for the treatment of heroin addiction. The prescribed treatment substitutes daily doses of methadone for the illegal heroin. Support for methadone maintenance treatment stems from the ability of the surrogate drug to address the addict's physical addiction to heroin and, subsequently, the social and criminal problems surrounding heroin use. Methadone maintenance treatment is, by most measures, the most

successful drug treatment program in use today. However, this medical model of using a surrogate drug has not proved successful in treating addiction to any drug other than heroin.

The clinical model developed in response to a need for community-based treatment to which substance abusers could turn in a crisis situation. The first phase of crisis clinics eventually evolved into longer-term treatment programs that counseled substance abusers to change established addictive behavior. Treatment professionals soon realized removal of addictive drugs was only one part of an overall treatment plan and the compulsion to use drugs must also be addressed. Clinical model approaches varied from residential to out-patient and immediate total abstinence, with alleviation of withdrawal symptoms followed by efforts to sustain abstinence, to a slow reduction of drug use with support services. Some programs made use of other prescribed drugs for short periods of time while others rejected the medical model and medication of any kind.

In the early 1970s, public opinion and policy directives had become intolerant of persons with substance abuse problems and of the clinical treatment approach. The focus of the drug problem shifted to the effects of substance abuse on society rather than on the individual addict. Substance abusers were now viewed as criminals, best dealt with by criminal penalties. By the mid-1970s, clinicians developed approaches to *prevent* substance abuse and associated criminal activity. Prevention strategies ranged from fear tactics (eventually abandoned as ineffective) to education, particularly for children, about drugs and their effects.

The drug problem emerged into national public view in the 1980s with the increased use of cocaine, especially crack cocaine, and the problem of poly-drug use (using more than one drug or a drug(s) in combination with alcohol.) Treatment professionals were unprepared for the onslaught of people, particularly the middle-class, women, and adolescents, abusing cocaine and the serious social ramifications, such as health problems, crime, single-parent households, and unemployment. Besides a client's drug use, treatment and prevention programs were forced to respond to a complex variety of social issues. Prior to this crisis, the predominate treatment method was the medical model (methadone maintenance) that serviced mostly adult male, heroin addicts.

Also in response, federal and state governments initiated the "war on drugs" and established even more severe criminal sanctions for drug use. Federal and state funds for treatment and prevention programs were cut and states were given block grants. Much of the money was redistributed toward law enforcement and interdiction efforts. For example, in 1989, federal funds for residential drug treatment were discontinued because substance abuse was reclassified as a mental illness and, therefore, not allowable under Medicaid regulations.

During the 1980s, the "Just Say No" prevention campaign was introduced by the Reagan administration and aimed primarily at children. The goal of the program was to deter a child's

first use of drugs. Eventually, this approach was found to be too narrow and simplistic, but was effective when used in conjunction with other prevention and treatment programs.

The most recent trend in substance abuse treatment has to do with the administration of services rather than the actual modality. The managed care model is currently being applied to many treatment systems and, in fact, Connecticut recently implemented, through the Department of Mental Health and Addiction Services, a statewide network of treatment services based on the managed care approach.

Key Points of Chapter III

State Substance Abuse Service Systems

- The criminal justice and treatment systems have the lead roles in implementing the state's drug and alcohol policies.
- Delinquent and criminal offenders under the age of 16 are adjudicated in the juvenile court (Family Division within the Judicial Department) and offenders who are at least 16 years old are processed in the adult criminal court.
- There are several statutory alternatives to prosecution and incarceration available to first-time offenders and those charged with non-violent crimes or possession of illegal drug offenses.
- The Departments of Children and Families and Mental Health and Addiction Services are responsible for providing substance abuse treatment services to children and young adults.

Chapter Three

STATE SUBSTANCE ABUSE SERVICE SYSTEMS

Introduction

The current state effort to address the use of illegal drugs and substance abuse by children and young adults (under 21 years of age) involves many state agencies and a myriad of state-funded, community-based programs. Initiatives are funded from several sources and cover prevention, intervention, treatment, and criminal justice activities. For example, the Department of Mental Health and Addiction Services (DMHAS) is the state's lead agency in treating individuals 18 years and older who have alcohol and drug abuse problems and the Department of Children and Families provides substance abuse treatment services to children under the age of 18. Additionally, the Departments of Education, Public Health, Social Services, and Veterans' Affairs and the criminal and juvenile justice systems also provide treatment services within their unique organizations.

As previously stated, the use of illegal drugs is commonly linked as either the cause or result of criminal activity. Based on that, public policy mandates the state's criminal justice and treatment systems respond to both behaviors, especially in juvenile cases. While some cases are processed strictly by the courts as criminal matters, others receive a joint response by the treatment and criminal justice systems. For example, adjudicated children and young adults can be ordered by the court into DCF or DMHAS treatment programs as part of their sentence for a crime or in lieu of prosecution or criminal penalties. Treatment as an alternative to incarceration is most commonly used for those children whose crime is strictly drug-related, such as possession of drugs, and who have committed no other criminal activity or delinquent behavior.

However, since not all convicted offenders abuse drugs and alcohol, treatment is not always ordered by the court. The court can order an assessment of an offender to determine if he or she has a substance abuse problem prior to disposition of the case and sentencing. Based on the assessment, the court can impose a penalty with or without conditions requiring substance abuse treatment. The DCF and DMHAS treatment systems are bound by court order and do not provide substance abuse treatment services to committed delinquents unless ordered to do so by the court.

This section describes the various components potentially involved in the state's effort to respond to juvenile substance abuse, connected or not to criminal activity. The types of services provided are broadly categorized as treatment,

intervention, prevention and education, social support, and criminal justice. As shown in Table III-1, there are 16 state agencies and the Judicial Department with active roles in administering or funding these services. It should be noted that this table is not all inclusive as other agencies may also have indirect or minor roles in these areas.

Table III-1. State Agencies' Substance Abuse Responsibilities by Service Type

Agency	*Treatment*	*Intervention*	*Prevention*	*Support*	*Criminal*
Commission of Deaf & Hearing Impaired	✓				
Department of Children & Families	✓	✓	✓	✓	✓
Department of Correction		✓	✓		✓
Department of Education			✓		
Department of Higher Education			✓	✓	
Department of Mental Health & Addiction Services	✓	✓	✓	✓	
Department of Public Health	✓	✓	✓	✓	
Department of Public Safety			✓		✓
Department of Social Services- Aging		✓			
Department of Social Services- Human Resources	✓	✓	✓		
Department of Social Services	✓				
Department of Transportation		✓			
Department of Veteran Affairs	✓				
Division of Criminal Justice- State's Attorney					✓
Judicial Department- Adult Probation			✓		✓
Judicial Department- Alternative Sanctions					✓
Judicial Department- Bail Commission					✓
Judicial Department- Family Division					✓
Office of Policy & Management			✓		✓
Public Defender Services Commission					✓

Source of Data: DMHAS State Agency Council on Substance Abuse report FY 94-95.

Connecticut focuses its resources for controlling the use of illegal drugs and substances in the criminal justice and treatment systems. Criminal justice activities cover detection, arrest, prosecution, and punishment. The services are provided by several state and local agencies, such as municipal and state police, juvenile and criminal courts, juvenile prosecutors and state's attorneys, the Department of Children and Families, the Department of Correction, and state-funded private community programs. The criminal justice system also has sole jurisdiction over delinquency and criminal matters. Children and young people who are arrested for a criminal offense are adjudicated in either the juvenile or adult courts.

Treatment services are offered in community-based settings and at several state facilities, operated or funded through the Departments of Children and Families, Correction, and Mental Health and Addiction Services.

Criminal Justice System

In Connecticut, the justice system is represented by four functional components: law enforcement; prosecutors; courts; and corrections. Each component is a distinct operational jurisdiction with its own organization, resources, sources of authority, lines of communication, and accountability. However, the components are linked in such a way that contact with one part of the system typically leads to contact with other components. The responsibilities and workload of each department are influenced and may be dependent upon the types and number of cases handled by agencies within the system.

Law enforcement. Federal, state, and municipal police departments are responsible for the prevention and detection of crime and apprehension of offenders. The Drug Enforcement Agency (DEA) is a federal law enforcement unit investigating the illegal drug trade and providing technical and investigative assistance to state and local police. The Division of State Police, within the Department of Public Safety, has statewide law enforcement jurisdiction. Within the state police special investigations bureau are the Statewide Narcotics Task Force and the Gang Unit, both of which have a prominent role in the area of substance abuse.

The narcotics task force, established in 1977 by the legislature, provides a cooperative law enforcement effort by state and local police focusing on the manufacturing, distribution, sale, and possession of narcotics and controlled substances. An interagency policy board directs and supervises the activities of the task force. The state police division is further required by statute to track and record gang-related activities throughout the state. The division's gang unit, in conjunction with local police, has developed procedures for monitoring, recording, and classifying gang-related crimes and data.

Also operating in the state are 91 municipal police departments, two municipalities with a constabulary unit, and police departments serving state university campuses, state and local agencies, and several private businesses. Local police have jurisdiction limited to the town in

which they serve except under specific circumstances, such as in pursuit of a felon, when it is expanded statewide.

Prosecutor. The Division of Criminal Justice is responsible for all state criminal prosecutorial functions. The division is comprised of the chief state's attorney, 12 state's attorneys, and 14 juvenile prosecutors. One juvenile prosecutor functions as an administrator at the division's central office. The state's attorney and juvenile prosecutor administer prosecutorial responsibilities for a specified judicial region.

It is important to note that recent legislation (P.A. 95-225) reorganizing the juvenile justice system transferred juvenile advocates (now called juvenile prosecutors) from the Judicial Department to the Division of Criminal Justice. Juvenile prosecutors have the same authority as the state's attorneys in charging and prosecuting young people under the age of 16. The juvenile and adult prosecutors are autonomous but coordinate the work of their respective offices.

Court. The state's judicial system is comprised of the Supreme Court, Appellate Court, Superior Court, and Probate Court. Except for the Probate Court, all courts are state-funded and judges are nominated by the governor and appointed by the General Assembly to eight-year terms. The chief justice is the head of the Judicial Department responsible for the operations of court system and also presides over the Supreme Court. The chief court administrator, appointed by the chief justice, is responsible for assignments of judges and administrative functions of the court.

The Superior Court is the sole trial court of general jurisdiction and has the authority to hear all legal controversies, except those within the jurisdiction of the Probate Court, and to sentence those defendants convicted of a criminal offense. The Superior Court is divided into four trial divisions: criminal; civil; family; and housing. There are 12 judicial districts (JD), or Part A courts, and 21 geographical areas (GA), or Part B courts. Generally, major criminal and civil matters are heard at JD courts while minor felonies, motor vehicle cases, and small claims matters are heard at the GA locations.

The state's juvenile court is divided into 13 districts presided over by Superior Court judges. Juvenile court is different from the adult criminal court because it is based on the belief that young people in trouble should be viewed as needing special care and guidance rather than punishment. The primary purposes of the juvenile court are:

- to ensure that children and youth under the court's authority have proper emotional, mental, physical, and moral care and guidance;
- to preserve and strengthen family ties whenever possible;
- to remove children and youth from their homes only for safety and protection reasons;
- to secure the care and discipline that is in the best interest of the children, youth, and community; and

- to ensure confidentiality of delinquency and family matters.

Corrections. The juvenile and criminal court can impose various sanctions, or penalties, upon convicted offenders. The most common are incarceration and community supervision. Incarceration services are administered by the Departments of Children and Families and Correction. The Board of Parole, Office of Adult Probation, and Juvenile Probation Unit provide community supervision services.

The Department of Correction (DOC) is the state agency that enforces court-ordered incarceration against pre-trial and convicted criminal offenders who are 16 years and older. The department administers 23 facilities, including the Manson Youth Institution and Maloney Correctional Institution that process male inmates between the ages of 16 and 21 years. All female inmates are housed at either the Niantic (minimum/medium security) or York (maximum security) Correctional Institutions.

Post-incarceration services are provided by the Board of Parole and the Office of Adult Probation. Parole is the conditional release of an inmate, under supervision, who has served part of the prison term for which he or she was sentenced by the court. The parole board is responsible for determining when an eligible inmate should be granted parole, what conditions to attach, and for supervision and case management. Once paroled, the law requires a parolee to serve the remainder of the full court-imposed sentence under community supervision.

The Office of Adult Probation is responsible for the supervision of convicted offenders referred by the courts and those eligible under presentence and alternative incarceration programs. Probation officers provide supervision and case management services. Probation can be court-ordered as the sole sentence or as a "split-sentence," which is a period of incarceration followed by probation supervision. The level of supervision ranges from minimal contact every few months to intensive daily or weekly contact.

Convicted delinquents, between the ages of 11 and 15, are committed by the court to the Department of Children and Families for an indeterminate period of time not to exceed 18 months for delinquents or four years for serious juvenile offenders. The juvenile court ordering commitment to DCF also directs or recommends to which placement options the child will be sent. The department determines the actual length of commitment, and maintains two placement options: Long Lane School and private residential programs. It should also be noted that although the children are committed to DCF, their parents retain all rights of guardianship, which requires their authorization for all placement, educational, medical, and treatment decisions.

Long Lane School provides the most intensive level of residential care and supervision for adjudicated boys and girls. The school has four residential cottages: one for girls and three for boys, one of which is a specialized substance abuse treatment program. The substance abuse treatment program, established in 1994, accepts up to 28 boys who are drug-dependent. Eligibility is subjective and on an individual case basis. The staff review the child's level of

dependency, history of drug use, and motivation for change. The program length is open-ended but children must stay for a minimum of 90 days.

The treatment program consists of daily treatment and recreational activities, school, individual and group counseling, and self-exploration and adventure exercises. The treatment follows the 12-step self-help modality of such programs as Narcotics Anonymous (NA) and Alcoholics Anonymous (AA). In addition, there is a family component in which the child's parent(s) participate in an eight-week program of substance abuse education, parenting skills, and suicide and relapse prevention classes. Parents are not required to participate and their failure to do so will not make a child ineligible for the program. The classes are held weekly on Friday evenings during the time allotted for extra visiting or picking up those children authorized for weekend home visits. Normal visiting hours are on Saturdays and Sundays.

Convicted delinquents are also placed in private residential facilities, funded by DCF. The facilities focus on treatment and reintegration into the family and community rather than security. Currently, the department funds five residential programs statewide and has recently contracted with two more to provide services to girls. One reason for the development of the new girls' programs is to address their unique treatment and medical needs.

All children directly placed in a residential program or released from Long Lane School to their parents' home are on parole status. Eligibility and granting of parole is done on an individual case basis by the school's case managers, counselors, and psychiatric staff. The staff review: the length of time the child was placed in Long Lane or a residential program; the crime committed; the child's behavior and any improvement or progress made; staff reports; and the child's conduct while furloughed for weekend visits.

If parole is granted, the case is transferred from a case manager to a parole officer and the child must agree to abide by certain conditions, such as curfew, school attendance, abstinence from drugs and alcohol, and their parents' rules. Special conditions restricting association with negative peers or from frequenting certain places may also be applied. Children paroled to a residential placement must agree to follow the rules of the program and participate in treatment.

Children sentenced to a period of probation are supervised by the Judicial Department's Juvenile Probation Unit. This unit provides individualized assessment and safe and secure treatment and rehabilitative services.

Juvenile Criminal Case Process

State law defines a child as a person under the age of 16 and a youth as a 16- to 18-year-old. It is the age at which the offense is committed and the severity of the crime that determines if the person will be handled by the court as a juvenile or adult. The Superior Court for Juvenile Matters has jurisdiction over all cases involving children up to the age of 15 while those 16 years and older are adjudicated in adult criminal court.

Types of cases. There are six types of juvenile cases. Delinquency and serious juvenile offenders (SJO) are handled in the criminal section, and family with service needs (FWSN), dependent, neglected, and uncared for children, termination of parental rights, and emancipation of minors cases are heard in civil court. In criminal cases it is the behavior of the child that is the cause of the court's intervention, whereas the care and safety of the child is the principal reason for the civil cases.

This study focuses on those cases adjudicated in criminal court: delinquency; serious juvenile offences; and violations of a court order involving a family with service needs cases. A delinquent child is one who has violated any federal or state law, municipal or local ordinance, or a Superior Court order. Delinquency cases are criminal proceedings. A child is adjudged a serious juvenile offender (SJO) when convicted of any one of specific offenses set out in statute. As shown in Table III-2, these crimes include the most serious and violent crimes which if committed by an adult would be serious felonies. The serious juvenile offender law categorizes the offender differently from other juveniles and transfers the case from juvenile to adult criminal court. It also requires placement in juvenile detention until the disposition of the charges. The SJO law also: permits longer periods of commitment to DCF; prohibits the child from returning to the community for a specified period of time; and requires the youth be released from detention only by a judge.

A serious juvenile *repeat* offender (SJRO) is any child under 16 years of age who is charged with a felony and has two previous convictions for delinquency. Convicted SJROs are subject to sentencing as both a juvenile and adult. This is the "three strikes" initiative for children.

Finally, a FWSN case involves a child who has run away from home, is habitually truant from school or defiant of school authorities, is beyond the control of his or her parents, or engaged in indecent or immoral conduct. These offenses, previously called status offenses, are not crimes but indicators of children at risk for delinquent or more serious problem behaviors. The court becomes involved to prevent future legal action, help resolve the problem, and strengthen the family ties. The intent is to process FWSN cases in a non-judicial manner while still affording support and structure to the family. These cases cannot directly result in placement in juvenile detention or commitment to DCF unless there is a violation of a court order, leading to a delinquency action.

Arrest. The flowchart in Figure III-1 shows the adjudication process of the juvenile court. Children and youth enter the system through an arrest by a police officer for a felony or misdemeanor crime or by referral of delinquent or disruptive behavior to police from a teacher, social worker, parent, or others. Referrals do not always result in an arrest of a child but, if the behavior is serious or repetitive, the case can be adjudicated by the court.

Table III-2. Statutory Serious Juvenile Offenses*			
C.G.S.	*Offense Description*	*Classification*	*Statutory Penalties*
29-35	Carrying pistol or revolver without permit.	unclassified	Fine up to $1,000 and mandatory 1- to 5- year prison term
53-80a	Manufacture of bombs	B	1-20 years prison term
53-390	Conspiracy to commit extortion.	B	1-20 years prison term
53-391	Advances of money or property to by used in extortion	B	1-20 years prison term
53-392	Extortion or conspiracy to commit	B	1-20 years prison term
53a-54a	Murder	A	25 years to life imprisonment
53a-54b	Murder of law enforcement or correction officer; for hire; second murder offense; by kidnap; by sexual assault; multiple victims; by sale of drugs; or by life sentence inmate.	capital	life imprisonment without possibility of release or death under C.G.S. 53a-46a
53a-54c	Felony murder during robbery, burglary, kidnaping, sexual assault, escape, or during committing or fleeing from other felony	capital	life imprisonment with no parole or early relapse
53a-54d	Arson murder	capital	life imprisonment with no parole or early release
53a-55	Manslaughter 1	B	5-40 years prison term
53a-55a	Manslaughter 1 with firearm	B	5-40 years prison term with 5-years not suspendable
53a-56	Manslaughter 2	C	1-10 years prison term
53a-56a	Manslaughter 2 with firearm	C	3-10 years prison term with 1-year not suspendable
53a-56b	Manslaughter 2 with motor vehicle	C	1-10 years prison term and mandatory 1-year suspension of driver's license
53a-57	Misconduct with motor vehicle	D	1-5 years prison term

Table III-2. Statutory Serious Juvenile Offenses*			
C.G.S.	*Offense Description*	*Classification*	*Statutory Penalties*
53a-59	Assault 1 (with weapon)	B	5-year prison term not suspendable for offender convicted of assault with weapon
53a-59a	Assault of victim 60+ years, blind, or disabled	B	5-20 years prison term with 5-years not suspendable
53a-59b	Assault of correction department employee	B	1-20 years prison term with sentence to run consecutively to the one for which the offender is serving at the time of assault
53a-60	Assault 2	D	3-5 years prison term
53a-70	Sexual Assault 1	B	1-20 years prison term with 1-year not suspendable
53a-70a	Aggravated sexual assault 1	B	5-20 years prison terms with 5-years not suspendable
53a-70b	Sexual assault of spouse or cohabitant	B	1-20 years prison term
53a-71	Sexual assault 2	C	1-10 years prison term with 9-months not suspendable
53a-72b	Sexual assault 3 with firearm	D	1-5 years prison term with 1-year not suspendable
53a-86	Promoting prostitution 2	C	1-10 years prison term
53a-92	Kidnaping 1	A	10-25 years prison term
53a-95	Unlawful restraint 1	D	1-5 years prison term
53a-101	Burglary 1	B	5-20 years prison term
53a-102a	Burglary 2 with firearm	C	1-10 years with 1-year not suspendable
53a-103a	Burglary 3 with firearm	D	1-5 years prison term with 1-year not suspendable
53a-111	Arson 1	A	10-25 years prison term
53a-112	Arson 2	B	1-20 years prison term

Table III-2. Statutory Serious Juvenile Offenses*

C.G.S.	*Offense Description*	*Classification*	*Statutory Penalties*
53a-113	Arson 3	C	1-10 years prison term
53a-122a(1)	Larceny 1 by extortion	B	1-20 years prison term
53a-123a(3)	Larceny 2 (property taken from another)	C	1-10 years prison term
53a-134	Robbery 1	B	1-20 years prison term except for Robbery 1 with weapon which receives 5-20 years prison term with 5-years not suspendable
53a-135	Robbery 2	C	1-10 years prison term
53a-166	Hindering prosecution 1	D	1-5 years prison term
53a-167c	Assault of peace officer; fireman; emergency medical staff; or correction, parole, or probation staff	C	1-10 years prison term with sentence to run consecutively for offenders convicted of assault on DOC staff
53a-174a	Possession of weapon or dangerous instrument in correctional facility	B	1-20 years prison term
53a-196a	Employing a minor (under 18 years) in an obscene performance	A	10-25 years prison term
53a-211	Possession of a sawed-off shotgun or silencer	D	1-5 years prison term
53a-212	Stealing a firearm	D	1-5 years prison term
53a-216	Criminal use of a firearm or electronic defense weapon	D	5 years prison term
53a-217b	Possession of a weapon on school grounds	D	1-5 years prison term

* Drug crimes under 21a-277 and 21a-278 are also included. See Tables 1 and 2.
Source of Data: Connecticut General Statutes

Pursuant to an arrest, a child must submit to having a photograph, fingerprints, and a physical description taken by the police. However, only the photographs of children charged with capital or class A felonies may be released to the public. The information on all other children is subject to the confidentiality laws surrounding juvenile records.

Once processed, the child may either be held in a juvenile detention center or issued a summons to appear in court and released to the custody of a parent or guardian. The Judicial Department operates three juvenile detention centers: Bridgeport; Hartford; and New Haven. The centers are housed in juvenile court buildings, and hold male and female children under the age of 16 years. The three detention centers have a combined total of 96 beds.

Within 24 hours of an arrest, excluding weekends and holidays, a detention hearing is held to decide if custody will be continued or if the child will be released pending disposition of the charges. Present at the hearing are the judge, juvenile prosecutor, probation officer, and the child's defense counsel. To continue detention, the court must find probable cause the child committed the delinquent act or violated a previous court order ***and*** one or more of the following grounds exists:

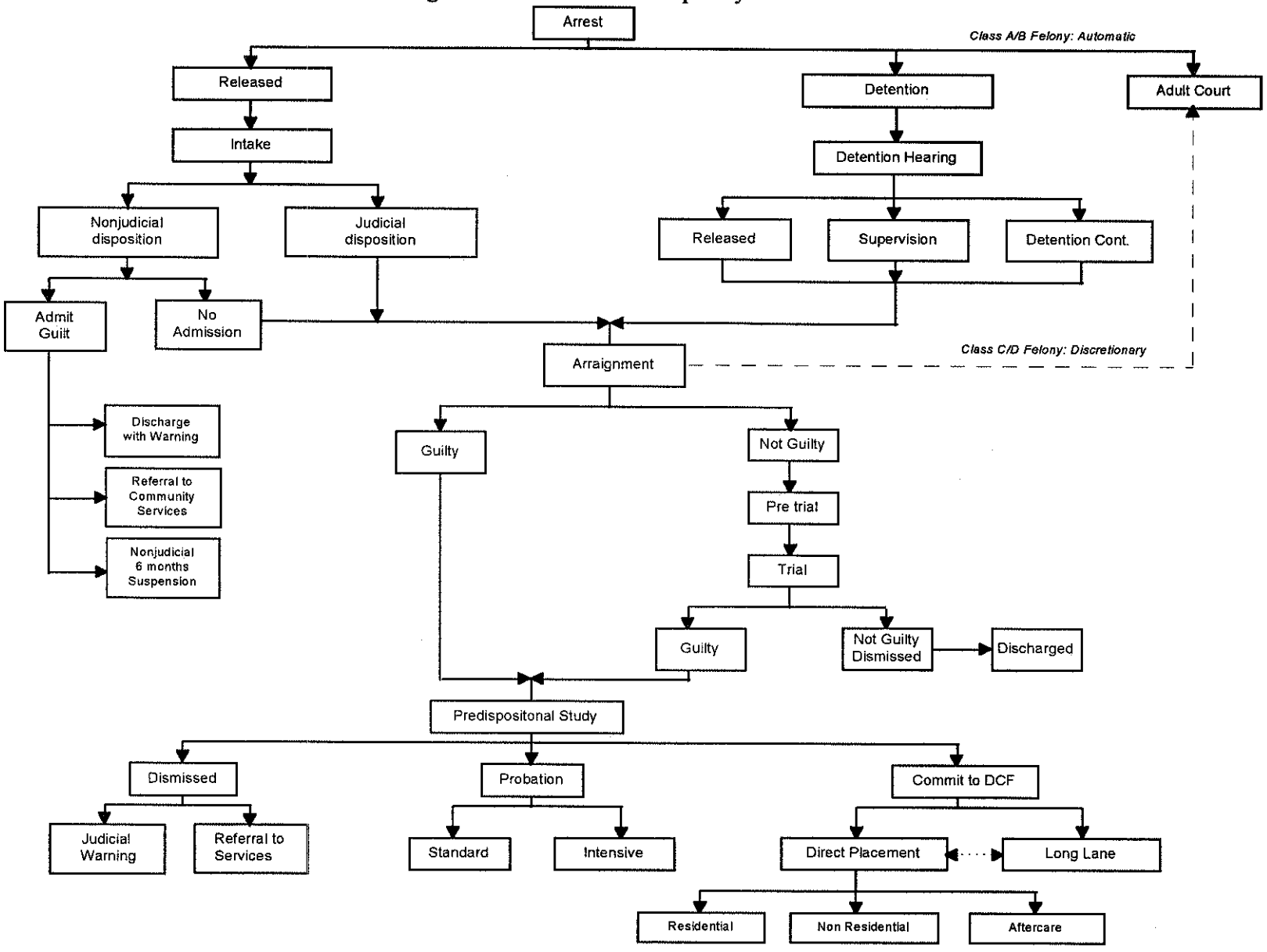
- the child will run away prior to court hearing or disposition;
- the child will commit or attempt to commit other criminal offenses;
- continued residence in the child's home is not in the best interests of that child or community because of the serious and dangerous nature of the pending charges;
- the child has a pending warrant from another jurisdiction; or
- the child has previously failed to respond to the court process.

A child's commitment status is reviewed by the court every 15 days and can be terminated at any time. If released from detention, a child is subject to supervision conditions, such as intensive supervision, electronic monitoring, random drug or alcohol testing, and regular school attendance. A violation can result in the return to a detention facility until the disposition of the pending criminal charges.

Serious juvenile offenders are not released prior to the case disposition and are held in juvenile detention centers. For those transferred to the adult criminal court, the child remains in a juvenile detention center until disposition or he or she becomes 16 years old, whichever comes first. At that time, the child is transferred to the custody of the Department of Correction and placed in an age-appropriate institution.

Court disposition. Juvenile delinquency matters are initially referred to the Judicial Department's Family Division for screening by the probation unit. The purpose of the intake process is to determine whether the facts of the case, if true, are sufficient to be a court matter and if the child's or community's interests require further judicial action. Additionally, a

Figure III-1. Juvenile Delinquency Case Process



pre-dispositional study (PDS) containing information on the child's (defendant's) crime, family life, school performance, social activities, work experience, and any other relevant information is completed. The PDS information is used by the probation unit and the court in disposing of the case. The criminal charges are then disposed of either informally by the probation unit with little or no court involvement (non-judicial) or by the court (judicial).

Non-judicial disposition. Cases processed non-judicially are generally less serious offenses, such as misdemeanors or class D felonies, committed by first time offenders or young children, 14 years or younger. In the best interest of the child, these cases are handled in an informal manner rather than in the court. The decision to non-judicially process a case is made by a probation supervisor and the case management is the sole responsibility of a juvenile probation officer.

As shown in the flowchart, if the child admits responsibility (pleads guilty) there is no need for a hearing to determine if the facts of the case are true. Non-judicial dispositions include: a dismissal of the charges with no further action; discharge with a warning involving no further court jurisdiction or supervision; assessment and referral to a community service program or treatment; or non-judicial supervision for a specific period of time, which may include conditions such as restitution, community service, and regular school attendance. Violation of any condition imposed by the court can result in further delinquency proceedings or sanctions.

If the child does not admit responsibility (pleads not guilty) for the offense, the case is forwarded to the juvenile prosecutor who can try the case or dismiss for lack of evidence.

Judicial disposition. Delinquency, serious juvenile offender, and some FWSN cases are handled by the juvenile court. A plea hearing (arraignment) before a juvenile court judge is the first step in the adjudication process. During the plea hearing, the child is apprised of his or her rights, informed of the pending criminal charges, and asked to enter a plea of guilty or not guilty. If the child pleads guilty to a felony charge there is no need for a trial and a dispositional (sentencing) hearing is held. For those children who plead not guilty, a trial date is scheduled. Pre-trial hearings to determine legal and factual issues surrounding the case may be held.

Generally, juveniles and adults have the same rights before the court although some legal protections and rights are provided only for adults, such as the jury trial. There are special safeguards reserved for children and youth. For examples, juvenile cases are closed to the public and separate from all other Superior Court business, court records are sealed and erased under certain conditions, and only those persons necessary to the proceeding and the victim are allowed in the courtroom.

If the judge finds the evidence does not support the allegations the: (1) case can be dismissed; (2) child found not delinquent (not guilty); or (3) charges nolle (*nolle prosequi*), which is a formal court motion by the prosecutor stating the case will not be prosecuted any further. If the court finds the child delinquent (guilty), a dispositional hearing is held.

Prior to the sentencing hearing, a pre-dispositional study is completed or updated by a juvenile probation officer and a sentence recommendation is made to the court. The juvenile court routinely accepts the recommendations of its probation officers. The most common sentences are:

- to dismiss with written warning or refer to community services or treatment;
- to impose standard or intensive probation with or without a suspended (not imposed) commitment to DCF and with conditions for supervision; or
- to commit to DCF for a period up to 18 months for delinquency or up to four years for serious juvenile offenses.

Any final decision of the juvenile court is appealable to the Appellate Court.

Transfer to adult court. As shown in the following table, the prosecution of certain cases are moved from the juvenile court to the adult criminal court by automatic transfer, discretionary transfer, or as a serious juvenile repeat offender. If transferred, 14- and 15-year-old children are adjudicated and, if found guilty, sentenced as adults.

Table III-3. Transfer of Juvenile Cases to Adult Criminal Court

Transfer Category	*Eligibility*	*Offenses*	*Procedure*
Automatic	Juveniles over the age of 14 years at the time of offense	Capital and Class A & B felonies and arson murder	Mandatory transfer to adult criminal court, Class B felonies may be returned to juvenile court upon prosecutor motion
Discretionary	Juvenile over the age of 14 years at the time of offense	Class C & D and unclassified felonies	Motion by prosecutor; ex parte finding of probable cause; approval by juvenile court judge; and court may return case to juvenile court
Serious Juvenile Repeat Offender	Juvenile over the age of 14 years at the time of offense	Any felony after two previous felony convictions at any age	Motion by prosecutor for SJRO proceeding; court grants request after hearing; juvenile declines to waive right to a jury trial; tried in juvenile court but sentenced as juvenile and adult

In the case of any juvenile transferred to the adult criminal court and not released while the matter is pending, the child will remain in a juvenile detention center or facility until he/she turns 16 years or is sentenced as any adult, whichever occurs first.
Source of Data: Family Division, Judicial Department and Connecticut General Statutes

By law, the prosecution of any child, at least 14 years old, charged with a capital or class A or B felony is automatically transferred from juvenile to regular criminal court and class C, D, or unclassified felony cases may be transferred with the court's approval. The child must be arraigned in adult court at the next court date and any case, except for a capital or class A felony, can be transferred back to the juvenile court within 10 days following the arraignment if the court finds it is in the best interest of the child.

The juvenile prosecutor can also petition the juvenile court to make the proceeding a serious juvenile repeat offender case, and the court has 30 days to hold a hearing and another 30 days to issue its opinion. SJRO status is granted if the prosecution shows "clear and convincing evidence" that it will serve public safety. The SJRO prosecution remains in the juvenile court if the child waives the right to a jury trial; however, if the child does not, the case will be transferred to the adult criminal court. Children prosecuted and convicted as SJROs in juvenile court are sentenced under both the juvenile and adult sentencing laws. The adult sentence is suspended (not enforced) if the conditions of the juvenile sentence are successfully met and no further crime is committed. If the conditions are violated or another crime is committed, the child is taken into custody and a hearing is held. If the court finds against the child, a sentence subject to initial adult limits is served.

A SJRO prosecuted and convicted in the adult court is sentenced as an adult. The child is incarcerated in an age-appropriate facility until he or she reaches the age of 16 and is then transferred to a correctional institution.

Alternative disposition. Juvenile law allows for an alternative method to resolve the cases of first-time offenders or those charged with less serious crimes who are drug or alcohol dependent. In lieu of prosecution, the children are ordered by the court to participate in substance abuse treatment, and the delinquency proceeding is suspended for up to one year. The charges are dismissed upon successful completion of the treatment program and any other court-ordered conditions. Children charged with a serious juvenile offense or who have previously participated in the treatment alternative are ineligible.

Penalties. As Figure III-1 shows, there is a range of sanctions imposed on children convicted of delinquency. The least severe is a written warning or referral to a community program that results in a dismissal of the charges. This sentence is imposed for first-time offenders or those found delinquent on minor charges.

Most adjudged delinquents are sentenced to probation with specific conditions imposed by the court. Children can be required to: participate in an intensive outreach or supervision program; random drug testing; counseling or treatment programs; attend school; or provide community service or victim restitution.

As previously noted, convicted delinquents may also be sentenced to periods of committment-- the term incarceration is not used for children-- in the custody of the Department

of Children and Families for up to 18 months for delinquency and up to four years for serious juvenile offenders. Typically, the court orders commitment for those children who are repeat delinquents, pose a danger to the community, or have been unsuccessful in community-based treatment.

Adult Criminal Case Process

The Superior Court's regular criminal court adjudicates misdemeanor and felony charges filed against persons who are 16 years and older and, as noted above, children 14 to 15 years old who are transferred from the juvenile court.

Arrest. The flowchart in Figure III-2 provides an overview of the adult criminal justice process. With few exceptions, adults enter the criminal justice system by an arrest. Arrest involves being taken into custody and detained by the police or issued a summons mandating a future court appearance and released. Pursuant to an arrest, an offender must submit to have certain information recorded by the police, such as fingerprints, physical description, and photograph.

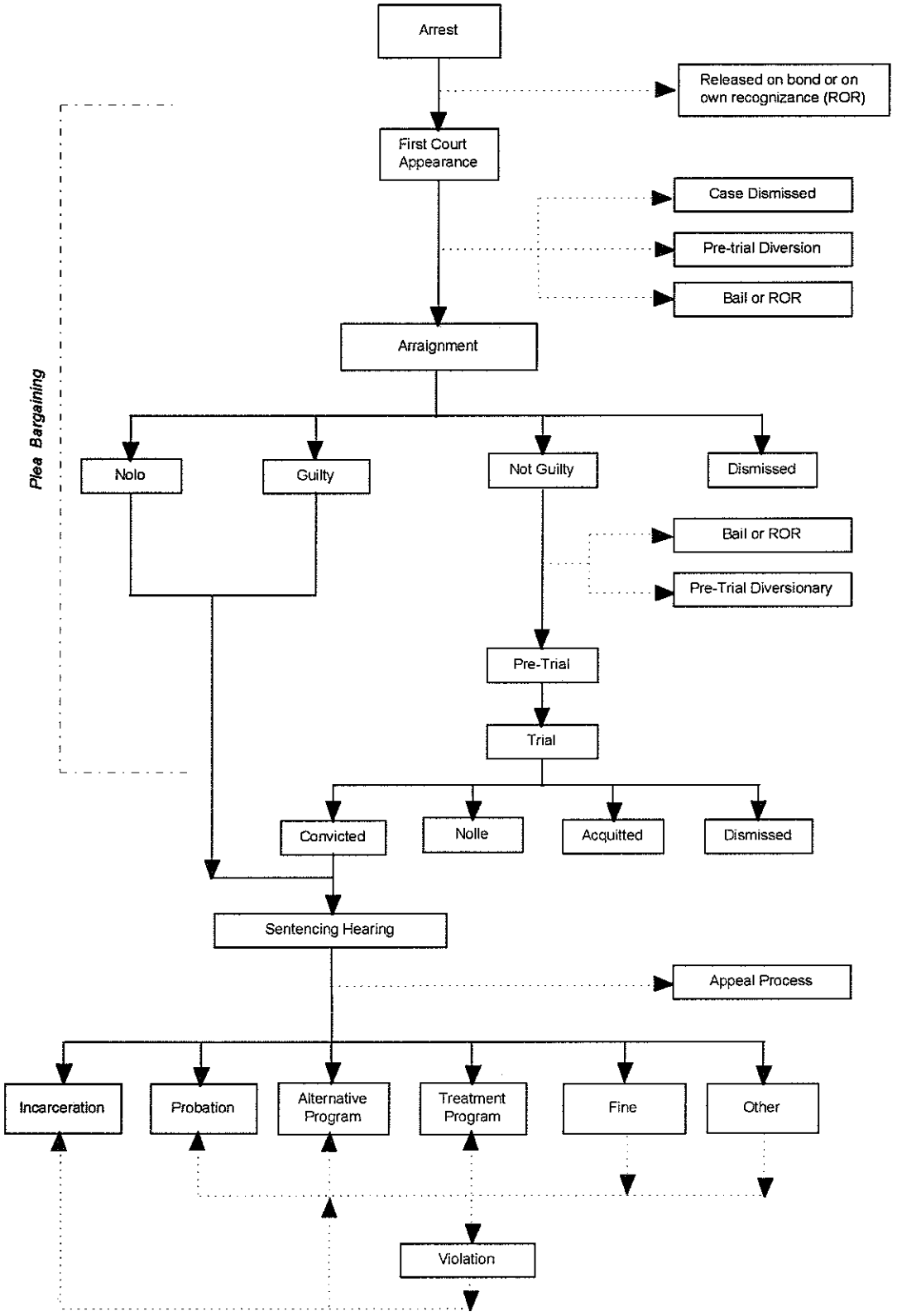
Case disposition. Adult offenders not released on bond or their own recognizance are held in detention facilities, known as jails, until the initial court appearance usually held on the next court date after the arrest.

First, defendants are given formal notice of the charges against them, advised of their rights, and the next court date is set. The second purpose of the hearing is to set bail if it has not already been done. The first court date (arraignment) is the gateway to the trial process and the defendant's first opportunity to respond to the pending criminal charges. The defendant is entitled to have an attorney present at the arraignment as well as all court appearances. At the arraignment the defendant may either enter a formal plea of guilty, not guilty, or nolo contendere to the pending criminal charges. *Nolo contendere* means "no contest" and is equivalent to a guilty plea but protects the defendant from having an admission of guilt used against him or her in a civil court proceeding.

If a guilty or nolo plea is entered by the defendant, the court must confirm that it is based on an informed and voluntary decision. Once this has been confirmed, the defendant is then scheduled for a sentencing hearing.

Defendants pleading not guilty are scheduled for trial. Unlike juveniles, adult defendants can opt for a jury trial. If a trial is held, the jury or judge renders a verdict on the guilt of the defendant based upon the evidence presented. If acquitted (not guilty), the defendant is free to go, but if convicted (guilty) of the charges a sentencing hearing is held.

Figure III-2. Adult Criminal Case Process



It should be noted that only a very small percentage (about 2 percent) of criminal cases actually progress to trial. The adult criminal justice system relies heavily upon plea bargaining, the process of negotiation between the prosecutor and defense counsel aimed at reaching an agreed upon disposition of the case. It is based on the prosecutor's authority to reduce the charges, dismiss or drop multiple charges, and make sentencing recommendations to the court.

Alternative dispositions. There are several statutory alternatives to prosecution available to first-time offenders, those charged with minor offenses, or defendants who are drug dependent. Included among these alternatives are: accelerated rehabilitation; alcohol education; community service; and substance abuse deferred case programs. All such programs are administered by the Office of Adult Probation, which supervises program participants and ensures compliance with court-ordered conditions. All of the programs allow for charges to be dismissed upon the successful completion of the program. Table III-4 describes the eligibility and exclusionary criteria for each program and the treatment requirements.

Table III-4. Alternative Sentencing Options for Adult Criminal Defendants

Program	*Status*	*Eligibility*	*Exemptions*	*Availability*	*Requirements*
Accelerated Rehabilitation (AR)	Pre-trial	1st time offenders minor crimes	Class A, B, & C felonies	restricted to once	up to 2 yrs probation & conditions
Alcohol Education	Pre-trial	1st time offenders DUI offenses	DUI causing injury	restricted to once	8 counseling sessions, treatment, license suspension
Community service labor program	Pre-trial	possession of drug charge	prior drug convictions	not restricted	community work for 2 to 30 days
Substance Abuse Deferred	Pre-trial & convicted	class D felonies & class A, B, & C if waived by court; and drug dependent at time of offense and need treatment	DUI offenders	not restricted for pre-trial restricted to once for convicted	out-patient or residential treatment for up to 2 yrs

Judicial outcome for successful completion of all alternative sentencing options is dismissal of charges.
Source of Data: C.G.S.

Accelerated rehabilitation (AR) is a pre-trial program for first-time adult offenders accused of a crimes "not of a serious nature." Persons charged with class A, B or C felonies and any youth previously adjudged a youthful offender are ineligible. A defendant can participate in AR only once. The program requires a period of probation for up to two years including court-ordered conditions, such as random drug testing, drug treatment, counseling, and community service. The criminal charges are dismissed upon successful completion of the AR program. If not, the offender is subject to prosecution of the original charges.

The pre-trial alcohol education program is available in lieu of prosecution to persons charged with driving under the influence of alcohol offenses, except if the crime caused serious

physical injury of another person. A defendant can only participate in the program once and it is reserved for first-time offenders. The pre-trial alcohol education program involves a minimum of eight alcohol counseling sessions or placement in a treatment program, whichever is recommended by a bail commissioner. During the program, the offender's drivers license is suspended. The criminal charges are dismissed upon successful completion.

The community service labor program is a pretrial diversion option for persons charged with possession of illegal drugs. The program requires a defendent to work on a community enhancement project, such as removing graffiti or picking up trash, for a period of two to 30 days. Those with prior drug possession and sale convictions are ineligible. Like the first two programs, the incentive to participate is the dismissal of the charges upon successful completion.

The court liaison program provides treatment instead of criminal sanction for drug-dependent persons charged or convicted of class D felonies; however, class A, B, or C felonies, except DUI offenses, can be included with an eligibility waiver from the court. DMHAS administers the assessment procedures to determine if the defendant was drug-dependent at the time of the offense and needs and will benefit from treatment. Upon a court order, the offender is placed in an out-patient or residential treatment program for up to two years and supervised by a probation officer.

Alternative sentences. In addition to the pre-trial programs, the courts have alternative sentencing options for convicted drug offenders, including probation or conditional discharge, alternative incarceration program (AIP), and the Youthful Offender (YO) program, which imposes community supervision with drug treatment and other conditions instead of incarceration. The courts have broad authority to impose a period of probation or conditional discharge as an alternative to incarceration for any conviction other than for a class A felony. The period of probation can range from five years for a felony to one year for an unclassified misdemeanor. The court may impose a sentence of conditional discharge, which is the least restrictive sentence, for an offense if probation supervision is not appropriate.

While on probation or conditional discharge, a defendant must comply with supervision conditions, such as drug testing and treatment, psychiatric treatment, residence in a residential community center or half-way house, or participation in a community service labor program. Failure to comply results in a violation of probation, which subjects the offender to the suspended portion of the sentence imposed at the time of conviction.

The alternative to incarceration program was established to divert jailbound offenders from incarceration thereby reducing prison overcrowding. Upon conviction for any offense subject to a prison term, the court can suspend the sentence and order participation in AIP as a condition of probation for up to two years. The program provides residential care, supervision, and support services such as employment, psychiatric and psychological evaluation and counseling, and drug and alcohol treatment. Supervision at a day incarceration center, intensive

supervision, electronic monitoring, and an order not to contact particular people can also be imposed by the court.

The law prohibits participation in the alternative to incarceration program by defendants convicted of: capital or class A felonies; criminal negligent homicide; manslaughter; misconduct with a motor vehicle; sexual assault in a spousal or cohabitation relationship; sale of drugs by a non-dependent; or a crime that has a mandatory minimum sentence.

The youthful offender program is an alternative that treats offenders who are 16 or 17 years old less harshly than adult offenders. Young adults charged with a class A felony, a felony level sexual assault, or who have previously been convicted of a felony or participated in the youthful offender or accelerated rehabilitation programs are ineligible.

Once YO status is granted, the court can: (1) commit the offender to a religious, charitable, or correctional institution for a period not to exceed the maximum sentence authorized for that offense; (2) impose a fine of up to $1,000; (3) sentence conditional or unconditional discharge or community service; (4) impose a sentence and then suspend it entirely or after a period of incarceration; (5) order drug or alcohol treatment; or (6) impose up to the maximum sentence for the offense. All police and court records are erased when the offender reaches the age of 21 years.

Sanctions. The sanctions available to the court in sentencing adult offenders are categorized as incarceration, community supervision, fines, or combination of the three. Incarceration is confinement in a correctional facility (prison or jail) for a fixed period of time specified by the court. The statutes set out a minimum and maximum sentence as guidelines for the court, which are detailed in Table III-5. In addition, certain offenses carry mandatory minimum sentences which must be served and cannot be reduced.

The Department of Correction administers the court's penalty and assumes custody of the offender after sentencing. The department cannot modify the length of the court's sentence, but it does determine the security and custody needs of the inmate and, by statute, can reduce the actual time served based on an inmate's good behavior (called good time).

Probation is a period of supervision that allows the pre-trial and convicted offenders to remain in the community either at their own home or in a residential program. Probation can also be imposed after a term of imprisonment. The primary goal of probation is to effectively address the needs of the client in an effort to reduce the likelihood of future criminal activity. Clients are classified as to their risk to re-offend and supervision standards are based on three levels: high; moderate; and low risk. The frequency and intensity of contact between the client and probation officer increases the higher the risk level.

Table III-5. Statutory Penalties for Felony Crimes	
Classification	*Sentence*
Capital	life without possibility of release or death
Class A Murder	not less than 25 years to life
Class A	not less than 10 years to 25 years
Class B Manslaughter	not less than 5 years to 40 years
Class B violent crimes*	not less than 5 years to 20 years
Class B	not less than 1 year to 20 years
Class C	not less than 1 year to 10 years
Class C Manslaughter	not less than 3 years to 10 years
Class D	not less than 1 year to 5 years
Class D violent crimes**	not less than 2 years to 5 years
Class D violent crimes***	not less than 3 years to 5 years
Unclassified	sentence specified in statute

* Violent crimes include: assault on person 60 years+ or disabled; sexual assault 1; kidnaping; burglary 1 with weapon; and robbery 1 with weapon.
** Crimes include: assault 2 on person 60 years+ or disabled; and possession of a firearm.
*** Crimes include: assault 2 with firearm on person 60 years+ or disabled; and criminal use of a firearm.
Source of Data: C.G.S. 53a-35a

Drug court. Recent legislation (P.A. 95-131) required the Judicial Department to establish a pilot program to adjudicate criminal cases involving drug-dependent offenders. Drug court is intended to reduce the reliance on incarceration as a response to the drug problem, provide treatment to nonviolent drug using defendants, provide early and continuing judicial supervision for nonviolent drug-dependent offenders, and reduce recidivism. In Connecticut, the "drug court" diverts offenders, between the ages of 16 and 21 years, charged with drug or other non-violent offenses into appropriate substance abuse treatment programs.

Since July 1996, the Judicial Department has operated a drug session in the New Haven Superior Court three days each week. A drug session is planned for Bridgeport in the near future. Under this 48-week program, drug-dependent defendants charged with possession of controlled substances can apply to have their cases transferred to a single docket dealing exclusively with drug cases. The authorizing statute does not restrict eligibility of drug-involved offenders according to the crimes with which they are charged. However, in designing policies and

procedures for the program, the Judicial Department limited participation to defendants charged with possession of drugs.

The focus of the drug session is to coordinate the responses of the judicial, treatment, social services, and education systems to help defendants get off drugs and reduce drug-related crime. The court maintains direct contact with the offenders on a regular ongoing basis during the program.

Defendants have various incentives for applying to the drug court. If accepted, those without prior criminal records can have the charges against them dismissed upon completion of the court-ordered drug treatment programs. If unsuccessful, defendants' cases are returned to the regular criminal court for disposition. Offenders with minor criminal records can plead guilty, with the agreement the court will vacate their pleas and dismiss the charges against them if they complete the programs. (Because the 48-week program has been operational since July 1996 no participant has yet completed the program.) Finally, offenders with more extensive records can plead guilty with the understanding they will face a particular term of incarceration or other penalty if they do not complete the court-ordered drug education and treatment programs.

Judges in other adult criminal courts have discretion to order these types of remedies, but three things make the drug session unique. First, the drug session deals exclusively with drug-dependent offenders. It is designed to channel these defendants into appropriate treatment programs, while providing ongoing incentives to keep them motivated and participating. The New Haven drug session has only one judge and, while their cases are pending, defendants are required to appear before the judge every two-to-four weeks. Second, prosecutors and defense attorneys play a less adversarial role in drug session than they do in traditional criminal courts. In the drug court, they function first as members of a team dedicated to the goal of rehabilitating the defendant. Each is involved in the decision of whether to admit an offender to the program. Third, the judge directly oversees the defendant's progress in the program. At any time, the judge can terminate the program and impose whatever sanction was agreed upon for failure. As an alternative, the judge can impose intermediate sanctions, such as confining the defendant to jail for a few days, but allowing the defendant to continue under the drug session's supervision. At every step in the process, the judge has a service coordinator available to provide referrals to appropriate treatment programs and design effective judicial responses.

Participants in the drug court program agree to several conditions: (1) one year of daily substance abuse treatment with random urinalysis; (2) bi-weekly court appearances in front of the same judge; (3) release of treatment information for court monitoring purposes; and (4) keeping all treatment and other required appointments. A defendant's progress is assessed by a team made up of the judge, court personnel, prosecution and defense attorneys, probation staff, and others.[5]

[5]Information obtained from the Law Revision Commission's January 10, 1997 report on the Drug Policy Study.

The Judicial Department's Office of Alternative Sanctions estimates it costs approximately $3,000 to supervise and treat a defendant in the drug court program, while it costs an average of $25,500 (based on estimates by the Department of Correction) to incarcerate a state prisoner each year.

Substance Abuse Treatment System

Treatment is designed to reduce the disability or discomfort and ameliorate the signs and symptoms of substance abuse. It is provided through medical and clinical (counseling) services. Medical treatment provides diagnostic services; detoxification to manage the withdrawal from alcohol or drugs; chemical maintenance which administers a stable dose of another chemical (i.e. methadone) as a substitute for an illegal drug, typically heroin; and care for related disease or illness. The clinical services offered include counseling, therapy, intervention, education, and other social services, such as housing assistance and vocational and educational training.

Department of Children and Families. The Department of Children and Families funds a network of community-based treatment programs and a residential facility for children under 18 years of age. Children receive treatment either voluntarily (non-committed) or involuntarily by court-ordered commitment to DCF as an adjudicated delinquent or as part of a family with service needs.

Non-committed. The department funds a statewide system of community-based programs, residential and outpatient, for children and families that voluntarily seek clinical treatment for substance abuse. Medical treatment is not provided. For outpatient care, DCF provides only referral service for families seeking treatment. The department has no role in assessment of need, development of treatment plans, or case management. Community-based service providers are contacted directly by the families, and all treatment decisions are made by the program, child, and his or her parent(s). However, if residential care is required, DCF is involved in the assessment of need, placement decision, coordination with community service provider, and case management, but, as noted earlier, the child's parent(s) retain all guardianship rights.

Requests for non-committed residential treatment services must be made by the child's parent(s) or guardian(s). Requests for placement are made to CareLine, a 24-hour, toll-free telephone "hotline," and then assigned to the appropriate regional office for a determination of eligibility. In addition to the clinical evaluation of the child's problem and treatment needs, the department determines the family's financial ability to contribute to the cost of care.

Although not handled on an emergency basis, DCF does receive requests for residential treatment for children who have been admitted to hospital emergency rooms for drug-induced psychosis, acute drug or alcohol use (alcohol poisoning), or overdoses. Upon discharge from the hospital, a child may be admitted to Riverview Hospital for Children and Youth for assessment prior to placement in a treatment program. Riverview is the only state-funded in-

patient psychiatric hospital that provides comprehensive evaluation and treatment for children, six to 17 years old, with severe mental or emotional illness.

DCF has 90 days to complete the assessment of any child requesting treatment and to recommend placement if the following eligibility criteria are met:

- the child is under 18 years of age;
- the child cannot be serviced in the family's home and has been diagnosed as in need of placement;
- there is a prognosis of a reasonably healthy parent-child relationship and the family will continue to maintain that relationship;
- placement is temporary and not to exceed 18 months;
- the child will return to the family home within the 18 months; and
- parents are financially unable to meet the total cost of treatment.

After placement, the DCF regional office monitors the child's progress and ability to return home. At the end of the 18-month treatment period, the child must: return to the parent or relative's home; be committed by the court to DCF based on a parental neglect petition; or be placed in alternative living arrangements or long-term care under other public auspices. The 18-month placement period may be extended in severe cases.

Committed. As described in the overview of the juvenile justice system, children under the age of 16 years who are adjudicated as serious juvenile offenders, delinquents, or members of a families with service needs can be committed by the juvenile court to DCF. Commitment periods for delinquents and FWSN cases are 18 months and up to four years for a SJO, and the department assumes guardianship of the child.

Substance abuse treatment for committed children is provided by DCF only when mandated by the court. The department does not have an intake assessment or screening process to identify drug and/or alcohol problems of committed children. This is done prior to adjudication by the juvenile probation unit. Court orders specify the type of treatment and placement option and, although the department is responsible for case management, it cannot alter the court's plan.

Department of Mental Health and Addiction Services. The Department of Mental Health and Addiction Services is the lead agency in the state's efforts in treating alcohol and drug abuse. It is mandated to establish client-based programs and services for the treatment of substance abuse consistent with the statewide treatment plan. The services must include emergency treatment, inpatient and outpatient treatment, intermediate treatment, and follow-up treatment including appropriate rehabilitation services. The department meets its mandate by funding a network of community-based programs and services and administering three residential treatment facilities.

The department provides treatment services to clients, 18 years and older, who are unable to obtain private care and treatment due to the severity or duration of their addiction or their lack of financial resources and:

- whose excessive use of chemicals impedes their ability to maintain an independent and functional lifestyle;
- are unable to remain substance free in a community setting for a period of time;
- have severe and prolonged substance abuse problems whose continued exposure would result in danger to themselves or others; or
- are pregnant women of any age with a substance abuse problem and their children.

Services are provided directly by the department or through a referred community program or facility. DMHAS may not refuse treatment services to any person because of a previous withdrawal from a treatment program or relapse.

The department's Office of Addiction Services (OAS) provides services to persons who are at risk, exposed to, or currently experiencing problems related to substance abuse. It consists of four divisions: Planning; Program Monitoring; Treatment and Coordination; and Prevention, Intervention, and Training, each headed by a director. OAS is assisted by 15 regional action councils (RAC), statutorily created to identify substance abuse problems, resources, gaps in services, and changes to the community; design programs; and develop and implement substance abuse treatment plans. The councils do not provide direct services to clients.

Delivery system. As previously stated, DMHAS currently funds community-based programs administered and operated by private service providers. The types of services provided are based on needs assessments, the statewide substance abuse plan, and historical funding practices. However, along with a new agency organization, DMHAS has developed a single statewide managed care treatment system. The managed care system, recommended in the 1996 report of the Governor's Blue Ribbon Task Force on Substance Abuse, was partially implemented in 1996 and is expected to be fully operational during 1997.

The new system operates through a regional managed service center and local service networks. The existing grants and aid funding process for community-based programs will change to direct services funding (e.g., fee-for-service). Although a new model for the administration of services is being implemented, a brief overview of the existing client eligibility criteria to obtain treatment for substance abuse is provided.

Direct services. By statute, an alcohol- and/or drug-dependent person may be admitted to an inpatient DMHAS treatment facility voluntarily, involuntarily, or by emergency status.

Voluntary. Any person who is at least 18 years old and is alcohol- and/or drug-dependent can apply for direct admission to a DMHAS-operated treatment facility and can withdraw from treatment at any time. A parent, guardian, or legal representative may apply for treatment for a person under 18 years of age. The facility administrator and medical officer approve all admissions and may, if admission is refused, refer the person to another department-operated or private treatment facility.

A police officer is authorized to assist any person found to be intoxicated in a public place or incapacitated by alcohol to voluntarily enter an alcohol treatment facility, hospital, or other facility. Although the person is considered to be in protective custody and escorted to a facility, it is not an arrest. The person can be admitted to a facility or hospital for inpatient treatment and detoxification. Family or next of kin must be notified promptly of the person's admission unless federal law prohibits notification or the patient, who is not incapacitated by alcohol, prohibits notification.

Within 48 hours, the patient is released unless further medical evaluation or treatment is requested. DMHAS will arrange for appropriate outpatient or intermediate treatment services, supportive services, residential placement, and transportation.

Under the new managed system of care, individuals can initially contact a statewide referral service, that is based on an emergency response system similar to 911. Clients will be immediately assessed by professional staff and either referred to emergency services or provided enough information or assistance until appropriate treatment services are obtained.

Involuntary. A person may be involuntarily committed to an inpatient substance abuse treatment facility by order of the Superior Court based on a petition filed by a spouse, relative, conservator or legal representative, physician, or administrator of a treatment facility. A commitment hearing for treatment is held within five business days after the petition is filed. If the petition is granted, the court may order commitment to a residential treatment facility for a period of 30 to 180 days if it finds "clear and convincing evidence" that the respondent is an alcohol- or drug-dependent person, who is dangerous to him or herself or others when intoxicated, or is severely disabled. The court may not order commitment unless a facility is able to provide adequate and appropriate treatment that is likely to be beneficial to the patient.

At the end of the commitment period, the client is released unless recommitted by the court for another period of 30 to 180 days. Recommitment is ordered if the client is still alcohol- or drug-dependent, is dangerous, disabled, or not successfully participating in an outpatient treatment program. The hearing is held within 10 days of filing the petition and the probable cause is the same as that of the original commitment hearing. A client may only be recommitted once after the original commitment period.

If recommitment is not sought, the client is automatically discharged and referred to an outpatient treatment facility for follow-up treatment. A person referred to an outpatient

treatment facility must remain in treatment for a period of 12 months unless discharged by the program administrator or a recommitment order for inpatient treatment is obtained.

Emergency. An alcohol- or drug-dependent person may receive emergency treatment at any DMHAS-operated or private facility if he or she: (1) is intoxicated at the time of application and is dangerous to himself or herself or others; (2) needs medical treatment for detoxification for potentially life-threatening symptoms of withdrawal from alcohol or drugs; and/or (3) is incapacitated by alcohol. A physician, spouse, guardian, relative, or any other responsible person may request emergency treatment.

A person cannot be detained for emergency treatment longer than five days. However, a petition for involuntary commitment may be filed by the facility administrator and the patient may be detained until the petition has been determined, but no longer than an additional five days.

Key Points of Chapter IV

Data Analysis

- Arrests of person under 21for drug offenses have been increasing since the early 1990s.
- Most drug offenses involving a person under 21 result in a not guilty or nolle verdict.
- Except for marijuana use which has been increasing since 1992, there does not appear to be a significant change in the use of other illegal drugs (e.g., cocaine, crack, heroin, inhalants) by young people.
- Younger teens showed the largest increase in marijuana use over the past few years, but treatment services are generally provided to older teens.
- Criminal justice data show the number of females involved in drug offenses is increasing.
- Less than half of young clients complete substance abuse treatment programs and, whether treatment was completed or not, about 70 percent showed no improvement or got worse with respect to their drug use and addiction.
- In addition to a substance abuse problem, many young offenders have complex service needs.
- The criminal justice system lacks sufficient information on a significant number of cases which prohibits a complete understanding of the prevalence and incidence of substance abuse among its offender population.

Chapter Four

DATA ANALYSIS

This section contains the program review committee's analysis of criminal justice and treatment data. Data from four different sources are analyzed. First, an analysis of national statistics on drug use and abuse and juvenile delinquency and crime is provided. Second, caseload data and descriptive information on clients from the juvenile and adult courts, probation units, and Departments of Correction, Public Safety, Children and Families, and Mental Health and Addictive Services are analyzed to provide an overview of the incidence of illegal drugs and crime committed by young people. Third, the committee conducted a case file review of a randomly selected sample of juvenile and adult criminal court cases in an effort to evaluate the prevalence of substance abuse based on the offenders' social and criminal histories. Finally, an overview is presented of a DMHAS study conducted under contract by Yale University. The study focused on the use of illegal drugs by juvenile and adult criminal offenders.

National Juvenile Statistics

Population. The juvenile population declined during the 1970s and early 1980s, but began to increase in 1984. In 1995, approximately 69 million juveniles below age 18 were living in the United States. The juvenile population is projected to continue to rise to approximately 74 million by the year 2010. The increase in population will itself lead to a greater number of juvenile victims, offenders, and cases in the juvenile justice system.

By comparison, Connecticut experienced an eight percent decrease in its juvenile population between 1980 and 1990. Table IV-1 shows, population projections by the Office of Policy and Management indicate a slight increase in the number of children and young people under the age of 20, particularly in the under 10 years and 10- to 14-year-old groups. The only age group showing a continuing decline is the 20- to 24-year-olds.

Drug and alcohol use. The best sources of national data on juvenile drug use are the Monitoring the Future Study (MTF) conducted by the University of Michigan and the National Household Survey on Drug Abuse by the federal Substance Abuse and Mental Health Services Administration (SAMHSA). The Monitoring the Future Study is a series of annual surveys

Table IV-1. Connecticut Juvenile and Young Adult Population Rates.								
Year	*Under 10*		*10-14*		*15-19*		*20-24*	
	number	*%***	*number*	*%*	*number*	*%*	*number*	*%*
1990	437,361	13.3%	194,372	5.9%	211,580	6.4%	251,701	7.6%
1995*	470,223	14.2%	212,113	6.4%	188,750	5.7%	196,715	5.9%
2000*	453,986	13.6%	233,402	7.0%	207,938	6.2%	176,254	5.3%

* 1995 and 2000 projected population rates based on 1990 Census data.
** Percentage of total state population.
Source of Data: *Connecticut Population & Household Characteristics*, Office of Policy & Management 1991 report.

of approximately 50,000 students, 18 years and younger, in more than 400 public and private schools nationwide. The National Household Survey, also conducted annually, provides data on the prevalence of illegal drug, alcohol, and tobacco use in the United States. It is based on a representative sample of the population 12 years and older.

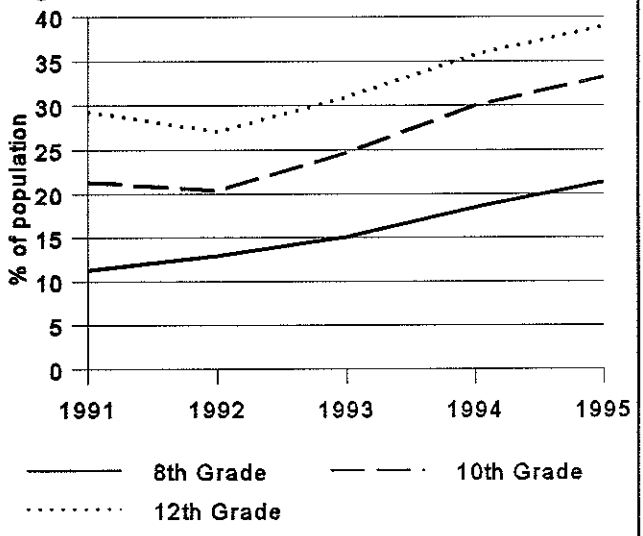
SAMHSA reported no significant increase in drug use among the overall population from the estimated 12.6 million people using illegal drugs in 1994 to 12.8 million in 1995. The number of persons presently using illegal drugs is about half of the peak rate in 1979 when 25 million were reported as current users.

However, the rates of illegal drug use show substantial variation by age. Among children 12 to 13 years, 4.5 percent were current users of illegal drugs but the highest rates of use were among young people 16 to 17 years (15.6 percent) and 18 to 20 years (18 percent).

Both the Monitoring the Future and National Household Surveys reported an increase in the rate of illegal drug use, particularly marijuana, among juveniles and young people. The increase continues a trend that began in 1992. The SAMHSA analysis showed an increase in drug use from 8.2 percent of youths 12 to 17 years of age in 1994 to 10.9 percent in 1995, which is approximately double the 1992 rate of annual drug use.

The 1995 MTF survey also found the use of illicit drugs among students increased in 1995. Figure IV-1 shows the MTF trend since 1991 in the prevalence of eighth-, tenth-, and twelfth-grade students who reported using drugs. High school seniors had the highest rate of use (39%); tenth-graders had the sharpest increase between 1993 and 1995; and eighth-graders showed the most consistent rise in reported use during the five years under analysis.

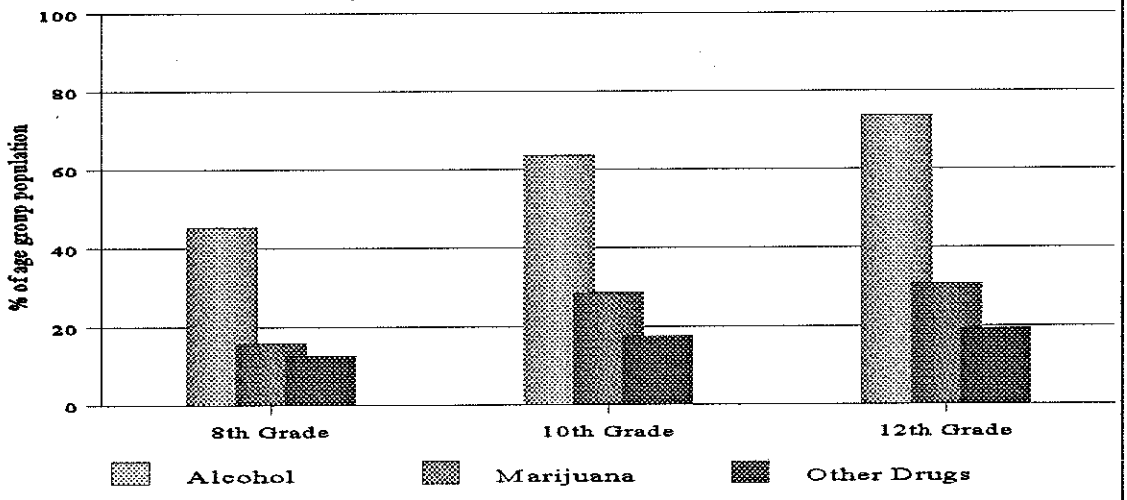
Figure IV-1. Prevalence of Annual Use of Illegal Drugs



Source of Data: MTF survey, 1995

As shown in Figure IV-2, the MTF survey found alcohol and marijuana were the most commonly used substances by school-aged children. In comparison, Table IV-2 shows the percentage of the grade level population using other illegal drugs and substances. Among the other types of drugs, inhalants (e.g., gasoline, White Out, etc...) were the most popular with eighth-graders and stimulants with the tenth-graders. High school seniors show a more even distribution among the other drugs, indicating greater experimentation and progressive addiction among a small percentage of the group. (Appendix A contains a descriptions of illegal drugs and narcotics and their effects.)

Figure IV-2. Prevelance of Use for Alcohol & Drugs 8th, 10th, & 12th Grades: 1995



Source of Data: MTF survey 1995

The use of LSD, hallucinogens, amphetamines, stimulants, and inhalants has only slightly increased since 1992. Cocaine and crack use has also increased but the rise has been more gradual than with other types of drugs. Finally, compared to other drugs, the 1995 prevalence

rates for annual use of heroin is very low (under 2 percent) for all age groups. The use of heroin has increased only slightly since 1991, but is still well below the peak levels reached in the 1970s.

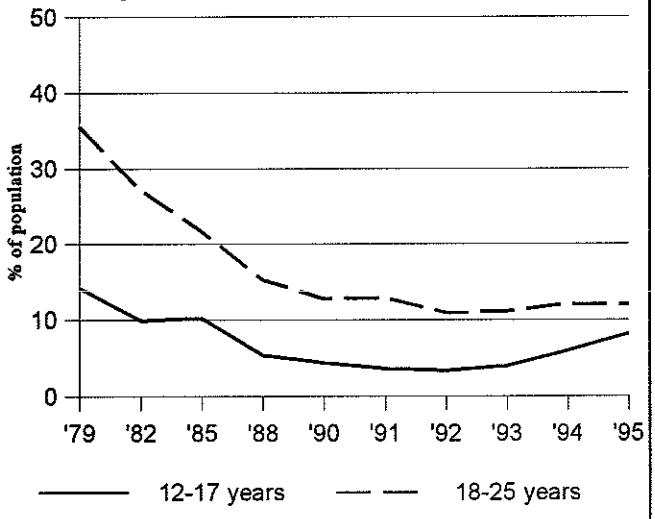
Table IV-2. Prevalence of Use of Illegal Drugs 8th, 10th, & 12th Grades: 1995

Type of Drug	*8th Grade*	*10th Grade*	*12th Grade*
Inhalants	12.8%	9.6%	8.0%
Hallucinogens (other than LSD)	3.6%	7.2%	9.3%
LSD	3.2%	6.5%	8.4%
Cocaine	2.6%	3.5%	4.0%
Crack	1.6%	1.8%	2.1%
Heroin	1.4%	1.1%	1.1%
Stimulants	8.7%	11.9%	9.3%

Source of Data: MTF survey 1995

As previously stated, the Monitoring the Future Survey rates are good indicators of the number of children and youths using illegal drugs and alcohol. However, the rates only include those children attending school and not those who drop out. The prevalence rates also do not differentiate between children who have used alcohol or an illegal drug only once and those that use daily, and they do not identify those children using more than one drug or a drug(s) in combination with alcohol.

Figure IV-3. Past Month Use of Marijuana



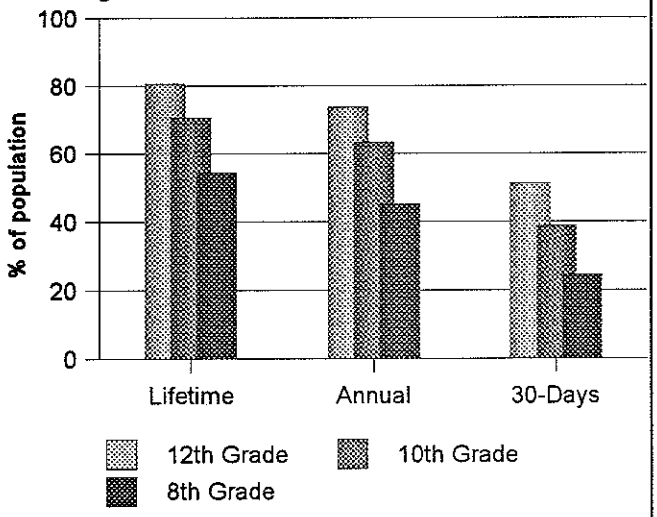
Source of Data: SAMHSA 1995

Marijuana is by far the most prevalent illegal drug used. SAMHSA reported, between 1994 and 1995, the rate of marijuana use among 12- to 17-year-olds increased from 6 percent to over 8 percent and, since 1992, the rate

of use for this age group has more than doubled. As shown in Figure IV-3, the trend in marijuana use (measured as using marijuana within the 30 days prior to the survey) by youth 12 to 17 years and young adults 18 to 25 years. The graph shows frequent use of marijuana declined throughout the 1980s, then began to increase in the 1990s, but is still no where near the rate of the late 1970s.

The National Household Survey found alcohol is the most commonly used controlled substance by the total population and is the most frequently used controlled substance among school-aged children. In 1995, almost 175 million people, 12 years and older, reported using alcohol at some time in their life and 111 million in the month prior to the survey, which indicated no significant change in rates of use between 1994 and 1995. In 1995, about 10 million current users of alcohol were under the age of 21 years, of which 4.4 million were binge or heavy drinkers.

Figure IV-4. Prevalence of Alcohol Use. 1995



Source of Data: MTF survey 1995

As shown in Figure IV-4, the Monitoring the Future Survey reported 81 percent of twelfth-graders had used alcohol at some time during their lifetime and a little more than half (51 percent) had consumed alcohol in the 30 days prior to the survey. In addition, 55 percent of eighth-graders reported using alcohol at least once. Whereas, marijuana is used by less than 50 percent of the juvenile population, cocaine and crack by less than 10 percent, and heroin by less than 2 percent.

Delinquency. Official records under represent juvenile delinquency because many juveniles are either never reported to authorities, never arrested, or not arrested for every delinquent act. While official records may be inadequate measures of the actual level of delinquency, they do monitor the juvenile justice system activity. The federal Office of Juvenile Justice and Delinquency Prevention's (OJJDP) 1996 report on juvenile offenders and victims provides the most recent national data available. As part of its analysis, OJJDP reviewed data from the Federal Bureau of Investigation's Uniform Crime Index, which compiles arrest statistics from law enforcement agencies nationwide.

In 1994, almost 3 million arrests of children under the age of 18 were made by state and local law enforcement agencies. Thirty-five percent of all 1994 juvenile arrests involved children

under 15 years of age. As shown in Table IV-3, juvenile males commit the majority (75 percent) of the crime resulting in arrest. The OJJDP further found juvenile drug arrests increased 42 percent between 1993 and 1994.

Table IV-3. FBI Uniform Crime Report on Juvenile Crime, 1994

Offense	*Juvenile Arrests*	*Sex*		*Ages*
	Nationwide	Male	Female	16-17 Yrs
Total Crime**	**2,714,000**	**75%**	**25%**	**45%**
Murder & manslaughter	3,700	94%	6%	71%
Rape	6,000	98%	2%	43%
Robbery	55,200	91%	9%	50%
Assault	85,300	81%	19%	48%
Drug Crimes	158,600	88%	12%	65%
Weapon Crimes	63,400	92%	8%	49%
Property Crimes	748,100	75%	25%	38%

** Includes all other crimes not specifically listed in table.
Source of Data: Nation Center for Juvenile Justice and FBI Crime in the US 1994.

Nineteen percent of all persons entering the justice system in 1994 for a violent crime were below age 18, representing less than one-half of 1 percent of all juveniles in the United States. Of all juvenile arrests, 6 percent were for a violent crime, of which one-half involved a child below age 16. Additionally, of the 3,700 juvenile arrests for murder and manslaughter, 71 percent (2,627) involved 16- and 17-year-olds. Between 1985 and 1994, the arrests of females under 18 years for violent crimes increased 125 percent from approximately 9,000 to more than 21,000 compared to a 67 percent increase for males. Although the increased rates of violent crime arrests of females is dramatic, females represent only 14 percent of the total annual arrest rate for violent crime.

Connecticut's Criminal Justice System

Arrests. The Connecticut Uniform Crime Report (UCR) tracks the number arrests for criminal offenses made by state and local law enforcement agencies. The UCR counts numbers of arrests and not numbers of criminal acts or charges. Therefore, persons arrested and charged with more than one crime will appear in the system only once. Typically, only the most serious charge is recorded. If an individual is arrested more than once during a year, each arrest is listed separately.

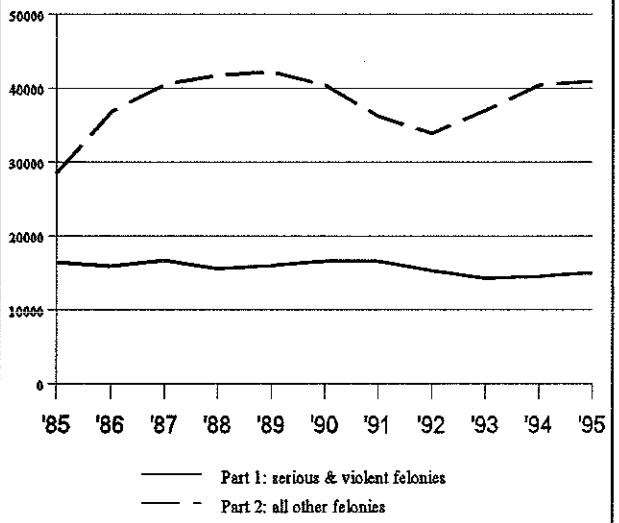
The UCR categorizes crimes into either Part 1 or Part 2 offenses. Part 1 offenses, the most serious and violent felonies, include: murder; manslaughter; assault; sexual assault; robbery; burglary; larceny and theft; and arson. Part 2 includes all other types of crimes, such as drug violations, driving under the influence of alcohol or drugs, simple assaults, vandalism, weapons violations, and disorderly conduct.

Overall, in 1995, local and state police made 55,970 arrests involving a person under 21, which represents 30 percent of all arrests made in the state. Of all arrests involving a person under 21, 13 percent (7,137) were for an illegal drug offense.

Figure IV-5 shows the trend in the number of arrests for Part 1 and Part 2 offenses that involved a person under 21 years of age. The trend in arrests for serious and violent offenses (Part 1) has remained fairly consistent over the past 10 years. Whereas arrests for Part 2 crimes, which include drug offenses, increased annually from 1985 through 1989, decreased during the next three years, and began rising again thereafter.

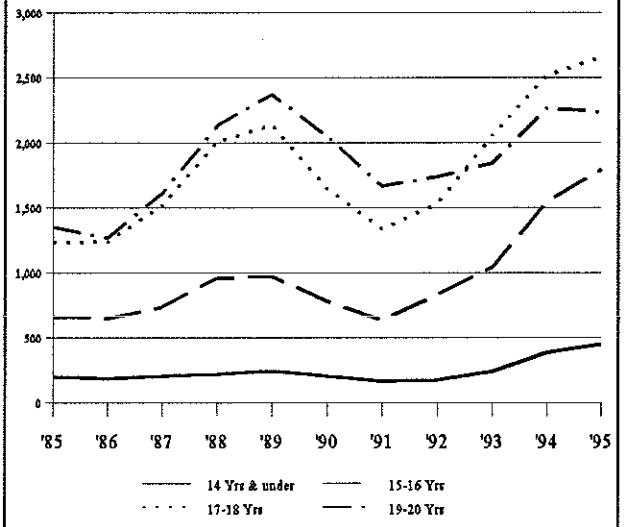
Figure IV-6 shows the trends in arrests for drug offenses, sale and possession, by age groups for those under 21 years of age. The graph shows that since 1991 drug arrests for each of the four age groups depicted increased. Note, that the sharpest increase occurred in the two age groups -- 15 to 16 and 17 to 18 that form the middle of the four age categories show in the graph.

Figure IV-5. Trend in Number of Arrests
For Persons Under 21 Years

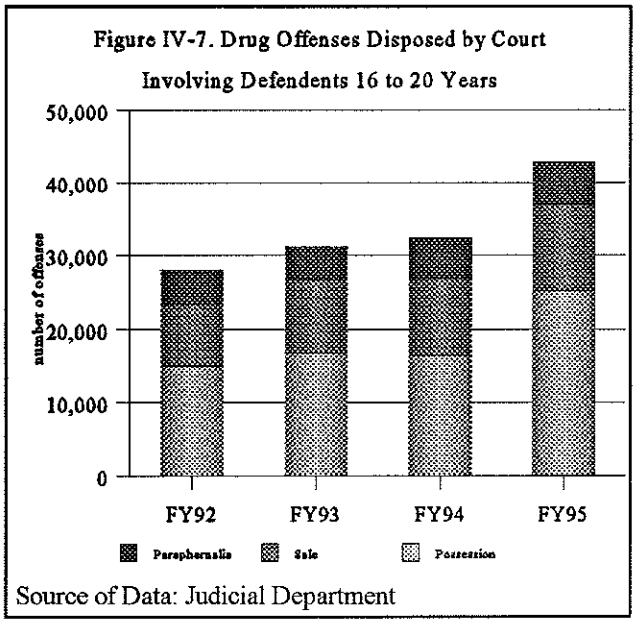


Source of Data: UCR 1985-1995

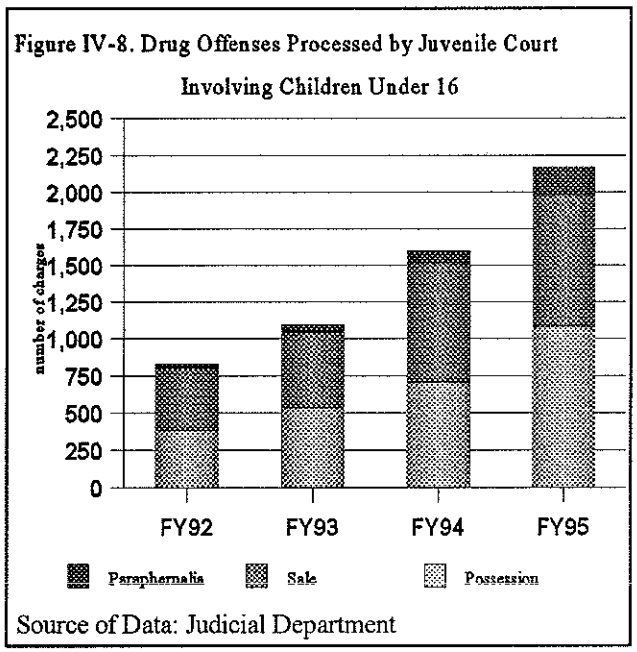
Figure IV-6. Trends in Arrests for Drug Offenses
for Juveniles & Young Adults



Source of Data: UCR reports 1985-1995



Source of Data: Judicial Department



Source of Data: Judicial Department

Court dispositions. Figures IV-7 and IV-8 show the trend in the number of drug offenses disposed by the state's adult and juvenile courts by type of charge -- sale, possession, and paraphernalia. Figure IV-7 shows that for each year under analysis, more than one-half of the drug offenses disposed by the adult court were for possession violations. The graphs shows a major increase in drug charges disposed by the court in FY 95, which is entirely the result of a 53 jump in the number of possession charges disposed.

Figure IV-8 shows the type of drug offenses involving children under 16 that were processed by the juvenile court. Unlike the adult criminal court, where the increase in drug offenses disposed has been driven almost exclusively by a rise in the disposition of possession charges, the increase in drug dispositions in the juvenile court is spread among all three offense categories.

Some interesting patterns emerged during analysis. Ninety percent of the children referred to the juvenile court with drug charges were male. Between fiscal years 92 and 96, males were predominately charged with sale offenses although in recent years more were faced with possession offenses. The percentage of drug offenses involving females under the age of 16 doubled from FY92 to FY96 and, while there are more female offenders in the adult age group, they still represent less than 20 percent of the sample.

Outcomes. The outcomes for illegal drug offenses also has remained steady. For each year between 1991 and 1995, approximately one-third of the drug sale charges resulted in a guilty

verdict and almost 70 percent in a not guilty or nolle[6] disposition. A small amount of cases were dismissed or received other dispositions, such as sentence modification.

Possession charges had a slightly lower rate of guilty verdicts (28 percent) and more dismissals and other types of dispositions than sale charges. However, like the sale offenses, about 70 percent resulted in a not guilty or nolle disposition. The only notable difference was in 1995, in that, there was a decrease in guilty dispositions (21 percent) and an increase in not guilty or nolle outcomes (78 percent).

The disposition rates for paraphernalia offenses were very different from sale and possession offenses. For each year examined, over 90 percent were resolved with a not guilty or nolle disposition and less than 10 percent were found guilty.

Probation services. The Office of Adult Probation and the Juvenile Probation Unit, within the Judicial Department, are responsible for supervising convicted offenders sentenced to community supervision programs either in lieu of or after a period of incarceration. Juvenile probation has a much greater role in the disposition and supervision of the case than adult probation, which handles offenders 16 and older. In fact, a juvenile probation officer often recommends the disposition outcome and sentencing, based on a social history investigation of the child and his or her family, to the juvenile court judge. Adult probation officers primarily provide supervision services after the disposition of the case. When ordered by the court, they also conduct pre-sentence investigations of the offender's social and criminal history.

A review of 16- to 20-year-old offenders on probation in 1994 show nearly two-thirds (63 percent) had no prior adult criminal record. Nineteen percent had one or two previous convictions, 13 percent had between three and six, and five percent had seven or more convictions. Eighty-seven percent of probationers between 16 and 20 years were male and 13 percent were female. More than one-half (54 percent) were white, 28 percent were black, and 18 percent were Hispanic.

In determining the level of supervision and type of program that is appropriate for each client, the adult probation unit conducts an assessment of offenders. The assessment includes self-reported information on the offender's drug and alcohol use. A review of data from 1994 cases found that 64 percent of offenders between 16 and 20 reported having no substance abuse problem, 29 percent indicated a minor to moderate drug problem, and less than 10 percent reported a serious problem. The levels of alcohol problems reported were slightly less than with drugs. Over 70 percent reported no problem with alcohol, 21 percent indicated a minor or moderate problem, and seven percent reported a serious problem.

[6]A *nolle prosequi* is a formal court motion by the state's attorney or juvenile prosecutor stating the case will not be prosecuted any further.

While on probation, an offender must comply with supervision conditions, such as substance abuse treatment, restitution, community service, or participation in an alternative incarceration program or center. Office of Adult Probation data, from January 1994, show that 27 percent of probationers were ordered to receive substance abuse treatment for a drug or alcohol problem.

Department of Correction. Sanctions or penalties imposed for violation of the drug laws include incarceration, fines, alternative to incarceration programs, and mandatory treatment programs. The total supervised correctional population (pre-trial and sentenced[7] inmates), either incarcerated or placed in the community, has remained stable since the early 1990s. However, the sentenced population has steadily increased with the requirement that certain inmates serve 85 percent of their court-imposed sentence. Over the past five years, the sentenced inmate population under 21 averages about 15 percent of the total DOC sentenced population. (Statewide, only about 7 percent of the total population is between the ages of 16 and 20 years.) Of those inmates under 21, approximately 31 percent were convicted of a drug offense: sale or possession. The correction department reported the average sentence length for young inmates convicted of a drug charge is three and one-half years.

Table IV-4 shows the number of sentenced inmates under 21 committed to the Department of Correction for drug offenses over a five year period. The data, which are divided into sale and possession offenses, provide an annual "snapshot" as of December 31 of each year. As shown, most of the inmates sentenced for a drug offenses are involved in the sale of drugs. The number of inmates involved in sale offenses has been fairly consistent with a slight increase from 1993 to 1994. The number of inmates involved in possession offenses has shown a similar trend.

Table IV-4 and Figure IV-9 show the trends in the placement of inmates in either a prison or community-based residential or day center. The changing patterns in the number of inmates in prisons versus the community was effected by several legislative changes and correctional policy decisions. During the 1980s, a DOC program, called Supervised Home Release (SHR), placed many inmates in the community to help reduce prison overcrowding. However, SHR came under severe criticism by the legislature, courts, and public because of the drastic reduction in time served by inmates prior to release and highly publicized incidents of criminal activity by SHR participants. SHR was legislatively phased out over a three-year period beginning in 1990. By the early 1990s, the state's prison expansion project was completed, the statutory prison population cap was repealed, parole was re-established in law and the authority of the Board of Parole was expanded, and finally parole eligibility was raised from 50 percent of time served to 85 percent. As shown in the graph, the trends in inmate placements then veered in different directions. The percentage of the inmate population incarcerated for drug offenses increased 42

[7]A sentenced inmate is one who has been convicted in criminal court and received a sanction of incarceration.

percent between 1991 and 1993 and has since remained consistent. The percentage of inmates placed in the community decreased at a comparable rate during the same time period and also level off.

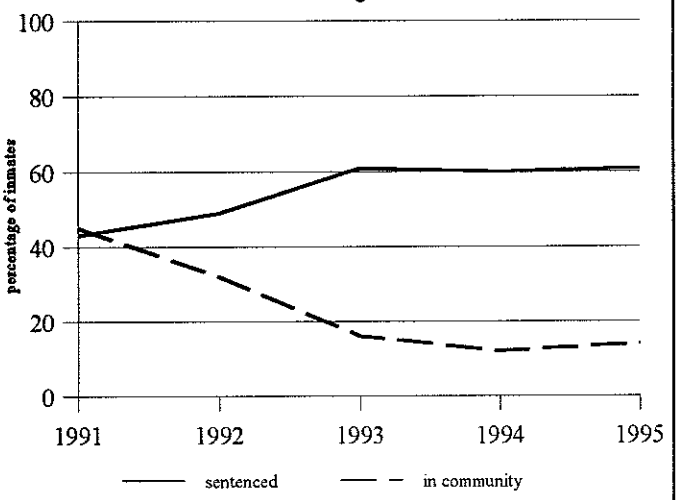
Table IV-4. DOC Sentenced Inmate Population, Under 21, for Drug Offenses

	1991	*1992*	*1993*	*1994*	*1995*
Drug Sale Offenses					
Sentenced	358	349	388	405	399
In Community	341	178	89	53	49
Subtotal	*699*	*527*	*477*	*458*	*448*
Drug Possession Offenses					
Sentenced	91	90	100	99	111
In Community	97	54	20	22	20
Subtotal	*188*	*144*	*120*	*121*	*131*
GRAND TOTAL	887	671	597	579	579

Data is snapshot of December 31 of each year.
Source of Data: Department of Correction

The Department of Corrections classifies all inmates, upon admission, as to the security level needed to properly and safely manage the prisons. In addition, the programming needs of the inmates are determined through substance abuse testing, educational and vocational testing, mental health and medical exams, and psychological testing. The substance abuse test determines the level of drug and alcohol use and addiction. The program review committee reviewed the drug test results for those inmates incarcerated at the Manson Youth Institution, which houses inmates 16 through 21 years, during August 1996. Of the 636 inmates tested, 79 (12 percent) had no or a minimal drug and alcohol use history, 143 (22 percent) had a moderate history with inconsistent use over the past two years, and 286 (45 percent) had a serious history involving consistent use or abuse over the past two years and at least one unsuccessful attempt at treatment. There were 128 (21 percent) inmates with chronic or long-term use and abuse of illegal drugs or alcohol that involved habitual use for more than two years, at least two stays in a medical detoxification program, and one unsuccessful attempt at treatment. Overall, approximately two-thirds of the sentenced inmates under 21 has a serious or chronic substance abuse problem.

Figure IV-9. Trend in Placement of Inmates, Under 21, Involved in Drug Offenses



Source of Data: Department of Correction

Substance Abuse Treatment

The Department of Mental Health and Addiction Services provides substance abuse treatment services to clients 18 years and older and to 16- and 17-year-olds who have been referred by the criminal court as part of the disposition of a criminal charge. The Department of Children and Families provides treatment services to children under 16.

DMHAS maintains a database on clients receiving substance abuse treatment from all licensed programs and facilities throughout the state that are state-operated or -funded or private. (A state-licensed, private treatment center does not receive state funds but is required to submit client information to the DMHAS.) Client information is reported by all licensed service providers to the department at admission and discharge.

The program review committee analyzed data from the DMHAS client information collection system covering state fiscal year 92 through fiscal year 95. The client data provided were for all clients of any age, for clients under 21 years, and for those under 21 referred for treatment by the criminal justice system. The criminal justice referrals came from local and state police departments, juvenile and adult courts, probation, correction department, bail commissioner, parole board, and public defender and defense attorneys.

Since July 1991, the department has serviced a total of more than 250,000 clients of all ages at state-operated facilities, state-funded community programs, and private treatment centers. Of the total clients, six percent (15,299) were under the age of 21, and 35 percent (5,415) of those were referred for treatment by the criminal justice system.

Age and sex. Of the criminal justice referral clients under 21, the average age at admission to a community-based program was approximately 18 years and 19 to DMHAS residential facility. The average age at admission to private facilities was slightly younger, approximately 17 years. However, clients as young as 10 have been admitted for substance abuse treatment.

During the four fiscal years under analysis, criminal justice clients were predominately male (90 percent).

Racial and ethnic distribution. Overall, the racial and ethnic distribution of young clients was 61 percent white, 22 percent black, and 17 percent Hispanic. Among the criminal justice group, minorities accounted for a larger percentage: 41 percent white; 35 percent black; and 23 percent Hispanic. This parallels the findings of the 1996 Judicial Branch Task Force on Minority Fairness which noted minorities are over-represented in adult and juvenile criminal courts compared to their numbers in the general population.[8]

School attendance. Not attending school is a significant factor in placing a child or adolescent at risk for substance abuse and criminal activity. As shown in the following table, the criminal justice clients had lower school attendance rates than clients referred by other sources. The criminal justice group recently increased school attendance -- from 31 percent in FY93 to 48 percent in FY95. Still, only about one half of all school-aged criminal justice clients were attending school at the time of their substance abuse treatment referral.

Table IV-5. School Attendance* by Substance Abuse Treatment Clients

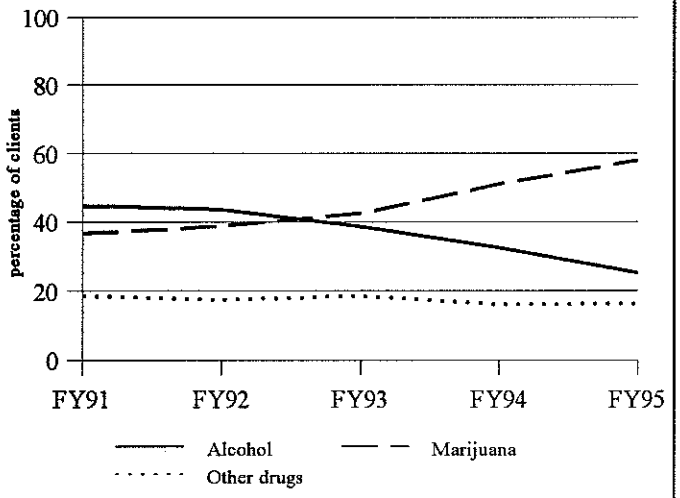
	FY92	*FY93*	*FY94*	*FY95*
Criminal Justice Referral Clients				
Attending School	26%	31%	37%	48%
Not Attending	74%	69%	63%	52%
All Other Referral Source Clients				
Attending School	60%	59%	55%	53%
Not Attending	40%	41%	45%	47%

*School attendance status reported at time of admission to substance abuse treatment.
Source of Data: DMHAS

Client drug use. For all clients under 21, including those involved in the criminal justice system, the reported age of initiation (first use) of an illegal drug or alcohol was predominately between the ages of 13 and 16. Most (52 percent) were between 13 and 14 years at first use. Overall, the most commonly used substances at initiation were alcohol and marijuana (83 percent

[8]State of Connecticut Judicial Department, *Judicial Branch Task Force in Minority Fairness: Full Report* (April 1996), pp 12

Figure IV-10. Drug or Substance Used by at Initiation by Criminal Justice Clients



Source of Data: DMHAS

combined). Trends shown by the DMHAS data are consistent with national and regional information.

The pattern of alcohol and marijuana use among clients under 21, particularly among those involved with the criminal justice system, has changed during the period under review. Figure IV-10 shows in the early 1990s alcohol was the most common experimental substance. There were several reasons for this, including accessability to alcohol, general acceptance among peers and adults, and it is typically less expensive than other drugs.

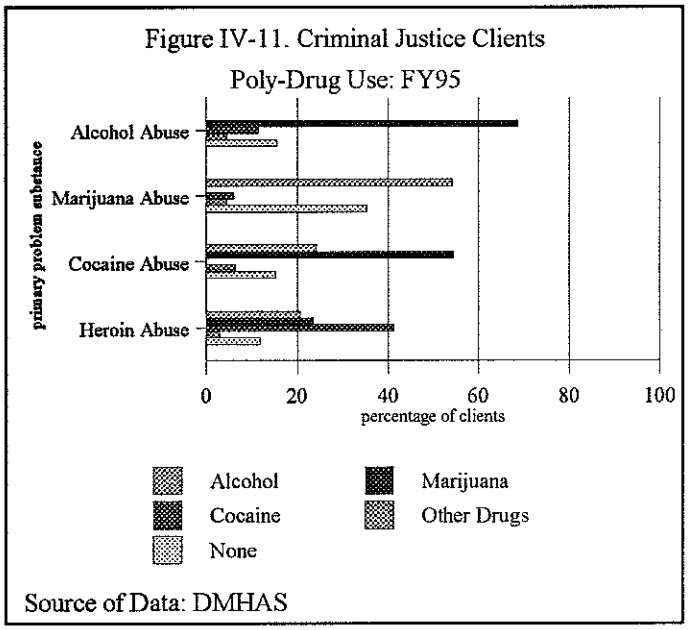
However, by fiscal year 93, the percentage of teens in treatment who used marijuana surpassed those involved with alcohol. By fiscal year 95, 58 percent of those in treatment had experimented with the drug while only 25 percent had consumed alcohol.

No definitive cause for the shift has been identified, but several factors have been set forth, including: greater accessability to the drug; growing acceptance of use among peers and adults; decreased cost of marijuana; increased quality of the drug; a strong domestic production system; and no negative public results of use, such as a celebrity overdose. This trend reflects national data which show marijuana use among teen-agers is increasing after years of decline.

Multiple drug use and the combined use of drugs and alcohol is increasingly common. Many people use additional drugs or alcohol to counteract and moderate or to heighten and enhance the effects of a particular drug despite the potentially dangerous and even fatal effects. Some common combinations include the use of heroin or alcohol to restrain a cocaine high and "speedballing", the intravenous use of both heroin and cocaine to moderate the post-cocaine crash or as a substitute for the methadone-blocked heroin high. Also, marijuana laced with another drug or chemical, such as formaldehyde or PCP, greatly intensify the mind altering effects of the drug and are particularly addictive.

The alcohol and drug combination is also dangerous and is used to create stronger or different effects than those obtained by using the substances separately. The combinations of

marijuana with alcohol greatly impairs performance. A current poly-drug use[9] practice popular among teens is smoking a "blunt", a large cigar wrapper filled with marijuana that is smoked slowly over an extended period of time, and drinking beer.



As Figure IV-11 indicates, 70 percent of criminal justice clients under 21 in treatment reported poly-drug use. The substance for which treatment is primarily being sought is shown down the left side of the figure and, within each primary problem category, the frequency of other drug use is shown.

Marijuana is the most common "other" drug of choice. Nearly 70 percent of clients receiving treatment primarily for alcohol abuse and more than one-half of those in treatment for cocaine abuse also used marijuana. Alcohol is also a significant factor in the patterns of multiple substance abuse. Only clients addicted to heroin show a different poly-drug use pattern with cocaine their most frequently used combination drug.

Treatment admissions. The number of clients under 21 admitted to DMHAS programs has slightly decreased between FY92 and FY95 from 3,230 to 3,019. The majority of young clients (85 percent) were first time admissions while the remaining 15 percent were readmissions, meaning the client had a previous treatment episode. The rate of readmission increases with the age of the client population groups. One reason for this is that addiction is a chronic, progressive, relapsing disorder. It is estimated that over 50 percent of all alcohol and drug patients are expected to relapse, and 61 percent of those who do relapse will do so many times.[10]

Table IV-6 describes the referral sources for all clients under the age of 21. Over the four year period under analysis, approximately one-third of the clients were referred for treatment by the criminal justice system, typically as part of an agreement to adjudicate a criminal charge or as a sentence for a conviction. The number of clients referred by the criminal justice system has

[9]Multiple drug use or the combined use of drugs and alcohol.

[10]Crow, A.H. and R. Reeves, *Treatment for Alcohol and Other Drug Abuse: Opportunities for Coordination* (U.S. Department of Health and Human Services, Rockville, MD), 1994

been decreasing each year from 1,256 in FY92 to 804 in FY95. In comparison, the number of referrals originating from the client and his or her family has been increasing each year. In fact, in FY95, client and family referrals were the most frequent source (33 percent). Referrals from the treatment system and doctor and hospital sources have also been increasing in recent years.

Table IV-6. Source of Referral to Treatment for Clients Under 21

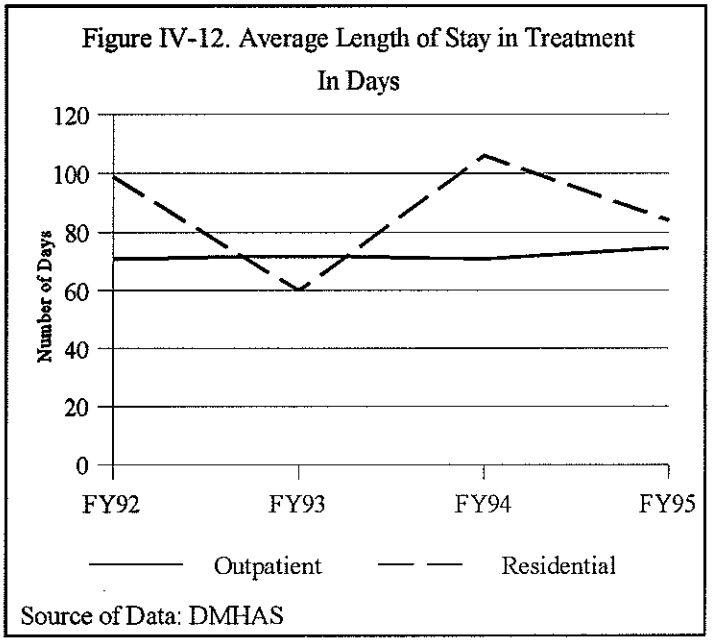
	FY92	*FY93*	*FY94*	*FY95*
Self & Family	704	649	840	982
School	222	165	217	255
Criminal Justice System	1,256	1,030	852	804
Treatment System	543	469	258	426
State or Local Agency	201	210	173	122
Medical & Hospital	267	292	314	397
Other	37	21	18	33
Total Referrals	3,230	2,836	2,672	3,019

Source of Data: DMHAS

During state fiscal year 95, more than one-half (57 percent) of all DMHAS clients under 21 received substance abuse treatment in an outpatient program and 20 percent were served in a residential treatment setting. Detoxification services were provided to 13 percent of the clients and less than one percent participated in a methadone or chemical maintenance treatment program. These programs generally restrict participation to clients who are at least 18 or, if under 18, to pregnant females.

Length of stay. The average length of stay for patients under 21 in treatment declined from 88 days in FY92 to 80 in FY94. Then jumped to 86 days in FY95. Lengths of stay differed, however, among the types of treatment programs. For example, in FY95, the average length of stay was 19 days in detoxification and 77 days in an alcohol education or prison program.

Figure IV-12 illustrates the trends in the length of stay in outpatient and residential treatment programs, the two most commonly used modalities for substance abuse treatment. As shown, the length of stay in an outpatient program has remained consistent at about 70 days over the past four fiscal years. In contrast, the length of stay in residential programs varied significantly from year-to-year. For the criminal justice referral group, the average length of



outpatient stay is similar at about 69 days. On average, the criminal justice group tended to stay slightly longer in residential treatment most likely because their participation was ordered by the court.

The Department of Mental Health and Addiction Services explained that the unstable pattern in the length of stay in residential treatment was not due to a change in policy or funding practices. It did note that the statistics for intensive, long-term residential treatment programs, which require lengthy periods of stay of one year or more but only serve a limited number of clients, could have resulted in the variation from year-to-year.

Discharge from treatment. Based on DMHAS data, 58 percent of criminal justice clients and 46 percent of all other clients under 21 do not complete treatment. There are no national or state standards defining successful treatment completion, however, the program review committee is concerned that more than one-half of clients do not complete treatment.

Also contained in the database is assessment information collected for all clients upon discharge, whether the program was completed or not. The assessment rates clients as improved, no change, or worse, with regard to their substance abuse problem. It should be noted that an improved assessment does not necessarily mean the client stopped using drugs or alcohol completely. It also can include those who decreased their use or stopped using a more harmful substance but were still using another. During FY95, 76 percent of the criminal justice clients who *completed* treatment were found to have improved their substance abuse status, 23 percent had no change, and only one percent got worse. However, for those who did *not complete* treatment, only 30 percent improved, 63 percent had no change, and 7 percent got worse.

Table IV-7 contains information on the types of discharge from substance abuse treatment programs and whether a referral was made for aftercare or another type of treatment. As shown, more than one-half of all clients are discharged from treatment without a referral for continued treatment, aftercare, or support services. This is significant given that addiction, as previously stated, is a chronic, relapsing disorder and that approximately one half of alcohol and drug

patients will require further and continued treatment. Additionally, about 25 percent of the clients are discharged from treatment programs due to continued drug use, misbehavior, criminal activity, or incarceration. These clients, the highest risk group in that they have exhibited the types of behavior most in need of treatment, also received no further service referrals.

Table IV-7. Criminal Justice Referred Clients: Type of Discharge from Treatment Program.

Discharge Type	*FY92*	*FY93*	*FY94*	*FY95*
Completed, with referral	4.8%	6.7%	9.3%	9.8%
Completed, without referral	35.6%	34.6%	33%	35.6%
Not completed, with referral	5.4%	5.8%	7.1%	7.9%
Not completed, without referral	21.8%	20.7%	21.6%	21.9%
Incarcerated	13%	11.1%	9.6%	4.3%
Noncompliance, drug use & other misbehavior	19.4%	21.2%	19.5%	20.5%

Source of Data: DMHAS

Random Sample Analysis

As part of the its research, the program review committee obtained demographic and case outcome information from a random sample of the Judicial Department's juvenile and adult criminal cases. The period of time covered by the data was July 1, 1994 through June 30, 1995. During this period, the adult court handled approximately 100,000 cases and the juvenile court about 50,000. The sample included 2,500 adult cases involving 16- through 20-year-old offenders and 1,500 juvenile cases concerning children under 16.

Juvenile cases. Eighty percent of the children involved in the 1,500 juvenile court sample were male. The racial and ethnic distribution was: 46 percent white; 34 percent black; 19 percent Hispanic; and less than one percent other. The largest age group of juvenile offenders (54 percent) were older adolescents between 15 and 16 years followed by the 13- to 14-year-olds (37 percent). Those under 13 accounted for six percent and over 17 years two percent.

Juvenile cases are generally disposed of in the judicial district in which the child resides rather than where the crime was committed because children generally commit crime within their

own communities.[11] Approximately 50 percent of the juveniles resided in a rural or suburban area and 40 percent in an urban area (10 percent resided out-of-state.) Of the 1,471 criminal offenses, 59 percent (868 crimes) were committed in an urban area. It should be noted that this is generally not due to children from rural and suburban communities going into urban areas to commit crime, although this does occur. For the most part, it is a small percentage of offenders responsible for the majority of the crime occurring in urban communities.

Table IV-8 presents a breakdown of the most serious offense the juvenile was charged with or the most serious offenses associated with the child's stay in a detention center. Like an adult offender, a juvenile can be charged with more than one offense. However, the judicial database only records the most serious. Eight percent of the offenses from cases included in the sample involved the sale or possession of illegal drugs and paraphernalia. One-third of the juvenile offenses involve disorderly conduct, criminal mischief, breach of peace, failure to appear in court, and other criminal misbehavior, and 27 percent were robbery, burglary, larceny, and theft crimes. Violence against persons, which includes homicide, assault, sexual assault, riot, arson, reckless endangerment, and risk of injury, represented 16 percent of the offenses.

Table IV-8. Most Serious Offense Charged Involving Juveniles: FY 94/95

Criminal Charge Type	*freq.*	*%*
Disturbance, Disorderly Conduct, and Other Offenses	491	32.7%
Robbery, Burglary, Larceny, and Theft	398	26.5%
Violence Against Persons	246	16.4%
Illegal Drug Sale, Possession, and Paraphernalia	119	7.9%
Serious Juvenile Offenses*	116	7.7%
Motor Vehicle and License Violations	84	5.6%
Weapons Violations	46	3.2%
TOTAL OFFENSES	1,500	100%

*Juvenile was charged under SJO statute rather than penal code statutes.
Source of Data: Judicial Department

[11]For the purposes of this analysis, a rural community has a population up to 16,000 residents, a suburban community has between 16, 000 and 50,000 residents, and an urban area has more than 50,000 residents.

Of the 119 illegal drug offenses, 25 were handled non-judicially by the probation unit and 94 were adjudicated in juvenile courts, of which 61 were nolled or dismissed, 21 resulted in a sentence of probation, and 12 ended in commitment to the Department of Children and Families.

Juvenile case review. A comprehensive case file review was conducted on a random sample of 150 juvenile court cases. The random sample was drawn from the sample of 1,500 cases obtained from the Judicial Department. Juvenile probation case files were reviewed for criminal, drug and alcohol use, family, education, and social histories. Probation files were available for all persons in the sample.

The most important finding during the case file review was *approximately 40 percent of the files did not contain any relevant social, education, or criminal history information and provided no substance abuse assessment information.*

The following information is based on the available data collected from 90 cases:

- illegal drugs were directly or indirectly involved in 72 percent of all criminal charges (marijuana in 33 percent of crimes and cocaine in 39 percent);
- 64 percent of juveniles reported they did not use illegal drugs, 44 percent indicated occasional use, and 4 percent reported chronic use; and
- 81 percent of juveniles reported they did not use alcohol, 14 percent indicated occasional use, and 5 percent reported chronic use.

Adult cases. The 2,500 random case sample from the adult criminal court involved persons between 16 and 20 years. Like the juvenile sample, most of the persons (81 percent) charged with criminal offenses were male. More than one-half were white, 30 percent were black, 14 percent were Hispanic, and one percent were other. The age group distribution was: 31 percent between 16 and 17 years; 42 percent between 18 and 19; and 27 percent 20 and older.

Similar to the juvenile sample, 53 percent of young adult offenders resided in rural and suburban communities, and over 60 percent of the crimes were committed in urban areas. Almost all (98 percent) were arrested by local police departments and the rest by the state police and state university and college police departments.

The 2,500 offenders were charged with a total of 4,538 criminal offenses[12], of which 839 (33 percent) were drug crimes. More than one-half (53 percent) of the drug crimes were possession of illegal drugs, 35 percent were sale, and 12 percent were drug paraphernalia.

Fifty percent (419) of all drug charges were nolled and 22 percent (187) were dismissed. A guilty verdict was recorded in 24 percent (202) of the charges and less than 1 percent were adjudged guilty. A sentence of incarceration and/or probation was imposed for 165 of the charges. The most common sentence (55 percent) was probation in lieu of serving the actual sentence imposed by the court: a suspended sentence. Twenty-seven percent of the sentences ordered a period of incarceration only and 18 percent were split sentences, in which a portion of the incarceration sentence was suspended thereby reducing the offender's time in prison followed by probation. The average period of probation was approximately three years, and incarceration sentences ranged from 45 days to 10 years with the majority falling between three-to- seven years.

Adult case review. A comprehensive review of court records and probation files was conducted on 10 percent of the 2,500 adult case sample. Probation files were available for slightly more than one-half of the sample. (The rest of the sample cases involved offenders who had not been supervised by the adult probation office for the current or previous offenses.) The committee reviewed pre-sentence investigation (PSI) reports and offender assessment instruments, which are completed by the probation staff based on self-reported offender information, state agencies' and the courts' documentation and records, and probation case notes. These reports contain the social and criminal history information used by the court in the adjudication and sentencing process and by the probation unit in determining the level of supervision and treatment required by the offender. The program review committee checked three additional sources of information on the 250 cases: (1) juvenile court and probation files to determine the offenders' prior juvenile criminal histories; (2) DCF records to identify offenders currently or previously involved in delinquency commitments, abuse or neglect cases, foster care, or family services cases; and (3) DMHAS client database to ascertain the incidences of substance abuse treatment and if treatment was received prior to or after arrest.

The most significant finding revealed by the program review committee during the probation case file review was *over 70 percent of the files failed to contain any relevant social or criminal history information or any substance abuse assessment information on the offender*. Most files simply served as a log of case processing, containing judicial forms on court actions, sentencing information, and some probation activity.

[12]It is important to note that an offender is often charged with more than one offense and a case will include all offenses charged during a single arrest. An offender may also be arrested more than once during a year and will have separate court cases for each arrest unless the state's attorney combines them.

Based on its analysis of information from the remaining 75 case files, the committee found:

- 12 percent of offenders had a documented drug abuse problem;
- 8 percent had a documented alcohol abuse problem;
- 63 percent of the offenders with a substance abuse problem had used marijuana, 11 percent crack cocaine, 8 percent cocaine, 3 percent alcohol, and 16 percent other illegal or prescription drugs, such as heroin and ritilin; and
- 12 percent had participated in some type of treatment or social service program.

The check of juvenile court records revealed 106 (43 percent) of the 250 offenders had prior juvenile criminal histories. Department of Children and Families records showed 56 (22 percent) had been involved in a DCF case. Of which, 21 were either the child or parent involved in a family case receiving family preservation or reunification services; 19 were committed to the department as delinquents and placed in Long Lane or a community supervision program; eight were children who were removed from their families' homes for reasons other than delinquency; and eight were children involved in abuse, neglect, or abandonment cases and placed in the foster care system.

A check of Department of Mental Health and Addiction Services records was done on 178 of the 250 offenders. DMHAS data is tracked by a client's social security number and judicial records did not provide the number for all offenders. Therefore, 18 (10 pecent) of the 178 offenders were identified by the department as having received substance abuse services between July 1, 1993 and June 30, 1996, for a total of 36 service episodes (9 individuals had more than one treatment episode). Eight offenders had received substance abuse treatment prior to their arrest for a total of 9 service episodes, of which only 4 were completed. The remaining 13 offenders received treatment after their arrest accounting for 27 service episodes, of which 13 were completed.

DMHAS Studies

The Department of Mental Health and Addiction Services contracted with the University of Connecticut and Yale University to conduct a series of studies on the prevalence and incidences of illegal drug use among adults, students, school drop-outs, and adult and juvenile criminal offenders. Five reports will ultimately be released through the department. The program

review committee obtained the preliminary data from the Substance Abuse Need for Treatment among Arrestee (SANTA) study.

The SANTA study, conducted by the Yale University School of Medicine, interviewed 700 randomly selected criminal offenders within 48 hours of arrest. One hundred juveniles between 12 and 20 years were included in the sample. It should be noted that offenders released on bond or promise to appear, hospitalized, or deemed dangerous or mentally incompetent were not included in the study.

Preliminary analysis of the juvenile data showed:

- by age 20, over 90 percent had used at least one illegal or controlled substance, mostly alcohol and marijuana;
- compared to adult offenders, juvenile offenders use of marijuana was much higher;
- during the 72 hours prior to arrest, older juveniles (18-20) had higher rates of use of alcohol, marijuana, and other illegal drugs, however, younger adolescents (13-17) reported more use of cocaine;
- 35 percent of the sample were dependent on at least one illegal drug or alcohol (based on self-reporting), indicating that one out of three met the need criteria for substance abuse treatment;
- however, of the 35 percent of juveniles who were drug dependent, only 37 percent reported they needed treatment, indicating approximately two-thirds voluntarily would not seek treatment.

Summary of Data Analysis

To summarize the criminal justice and treatment information presented above, the Legislative Program Review and Investigations Committee found:

- *Arrests of persons under 21, as a percentage of all arrests statewide, have declined 25 percent from the mid-1980s. However, among this age group, arrests for drug offenses (especially possession) have been increasing.*

- *Beginning in 1994, the number of drug possession cases disposed of by the juvenile and adult courts has increased.*

- *Most drug offenses involving a person under 21 result in a not guilty or nolle verdict (70 percent or more for sale or possession and 92 percent for paraphernalia).*

- *A very small portion (three percent) of the DOC population are inmates under 21 who were charged with or sentenced for a drug offense.*

- *Except for marijuana use which has been increasing since 1992, there does not appear to be a significant change in the use of other illegal drugs by young people.*

- *Younger teens (12 through 15) showed the largest increase in marijuana use, but treatment services are generally provided to older teens (17 through 19 years).*

- *Substance abuse treatment clients are predominately male but criminal justice data show the number of females involved in drug offenses is increasing.*

- *Less than one-half of clients under 21 complete substance abuse treatment programs, and 71 percent of all clients, whether treatment was completed or not, showed no improvement or got worse;*

- *In addition to a substance abuse problem, many young offenders have complex service needs in areas such as education, employment, family structure and management, peer groups, and health care.*

- *The criminal justice system lacks sufficient information on a significant number of cases (70 percent for young adults and 40 percent for juveniles) which prohibits a complete understanding of the prevalence and incidence of substance abuse among its offender population.*

Key Points of Chapter V

Findings and Recommendations

- Existing substance abuse policy evolved by default and not based on data analysis or outcome monitoring.

- Current substance abuse policy does not sufficiently focus on a public health approach.

  - **Public policy shall address substance abuse as a public health problem and coordinate state efforts.**

- There is no systematic or coordinated effort to evaluate substance abuse services.

- General Assembly has no effective means to determine benefits derived from substance abuse treatment programs.

  - **Office of Policy and Management (OPM) shall establish uniform policy and procedures for collecting and evaluating substance abuse data.**

  - **OPM shall establish a central repository of data.**

- State system does not lend itself to a comprehensive response to young offenders or the problem of substance abuse.

  - **Establish Substance Abuse Policy Council and OPM develop state substance abuse policy.**

- Connecticut has elements of a system of graduated sanctions but does not coordinate case management.

- Existing law and judicial practice hampers efforts at a graduated sanctions model.

  - **Expand Superior Court's drug court program.**

  - **Repeal restrictive statutory language concerning alternative sentencing options.**

  - **For offenders under 21, repeal mandatory minimum sentences for drug offenses.**

Chapter Five

FINDINGS AND RECOMMENDATIONS

The Legislative Program Review and Investigations Committee's findings and recommendations for state substance abuse policy for persons under 21 address three main issue areas. The first is the development of substance abuse policy. The second focuses on the coordination among state agencies, specifically the criminal justice and treatment systems, in implementing policy. The third area covers criminal justice policy issues related to substance abuse and delinquent or criminal activity by young people.

Substance Abuse Policy

Traditionally, Connecticut has relied heavily on the criminal justice system for the solution to drug and crime problems. Although penalties and sanctions are important components of the state's drug policies, the criminal justice system alone cannot solve the problem. State policy has embraced substance abuse treatment and, to a lesser extent, has marginally dealt with prevention and education.

Persons with substance abuse problems, especially children and adolescents, have complex service needs not easily and effectively addressed by the justice system or a single state agency. Research on substance abuse indicates the risk factors leading to drug use are the same as those for juvenile delinquency and crime, school failure, family and community violence, and other social problems affecting children. Framing the substance abuse problem as a public health issue allows for the inclusion of prevention, education, and treatment measures as well as criminal justice initiatives in the development and implementation of a comprehensive state drug policy. It further allows for a broader base of services that have the capacity to deal not only with a single issue, like drug addiction, but address other risk factors.

From its review of the state substance abuse policy, the program review committee found:

- *Existing substance abuse policy evolved by default from a reliance on historical service and funding practices, and not as a result of informed policy decisions based on a system-wide data analysis or outcome monitoring process.*

- *In the absence of a comprehensive and coordinated approach, the incentives for state agencies to implement a substance abuse policy are limited to what each agency considers to be in the best interest of its own clients and fiscal and administrative needs.*

- *Furthermore, the state's current substance abuse policy emphasizes the reduction of the availability of illegal drugs through criminal sanctions. The program review committee believes it does not sufficiently focus on a public health approach that includes treatment, prevention, and education.*

The program review committee recommended Connecticut's public policy shall address substance abuse as a public health problem that shall be dealt with through prevention, education, and treatment efforts in addition to criminal sanctions. The state's substance abuse policy for juveniles and youths shall be comprehensive and result in the coordination of efforts by relevant state agencies and the Judicial Department to:

- **help youth recognize the risks associated with drug use;**

- **create safe and healthy environments in which children live, learn, and develop;**

- **strengthen multi-agency linkages at the state and community levels; and**

- **reduce drug-related crime and violence through a system of graduated sanctions in addition to punitive measures.**

To improve future planning decisions and management of substance abuse and social services, the concepts of outcome monitoring and performance data analysis must be incorporated in state policy development. An information system that: establishes a basis for continuous and comprehensive monitoring of programs and services; identifies and measures the effectiveness of the services; tracks changes in access and costs; and provides an overview of the service needs and client demographics should drive public policy decisions.

At present, three basic problems make it difficult to compare and analyze substance abuse data: (1) a lack of standardized data collection methods; (2) a lack of an automated interagency organization to gather and process different types of data; and (3) confidentiality issues.

With respect to the first problem, agencies (e.g., DMHAS, DCF, DOC, and Judicial Department) vary considerably in data collection and outcome monitoring efforts. Over time, each one has developed an automated or manual tracking system based on its unique needs.

While many agencies serve the same clients, a common client identifier was not developed. For example, persons involved with the criminal justice system are processed through several agencies, however, it is extremely difficult to track services received throughout the system. This becomes even more difficult when the individual accesses the treatment system.

In terms of the second data analysis problem, there is little consistency in the types and levels of automation among state agencies and community-based programs involved in substance abuse services. For many programs, data are not easily accessible or up-to-date. Community-based programs responsible for providing much of the substance abuse treatment services seldom have automated or even defined systems for recording and reporting data. The end result is state agencies responsible for providing substance abuse services also do not have the data required for making sound fiscal and policy decisions.

Finally, much of the data relating to substance abuse treatment and juvenile criminal records are protected by federal and state confidentiality law and regulation. This poses two problems: (1) how to obtain client-specific data without violating privacy law and regulation; and (2) how to release enough descriptive data from one agency to another to build a systemwide database. Based on its examination of the current system and efforts at a systemwide data analysis, the program review committee found:

- *There is no systematic or coordinated effort to monitor and evaluate state-funded or -administered substance abuse services. Overall, interagency client-based outcomes and measures as well as compatible data collection efforts are lacking.*

- *The General Assembly has no effective means to determine and verify if there are any benefits derived from appropriations and expenditures for substance abuse treatment programs and other related services.*

Therefore, the program review committee recommended the secretary of the Office of Policy and Management shall establish uniform policies and procedures for standardizing, collecting, managing, and evaluating: (1) client demographic and substance abuse and addiction information; (2) the use of prevention, education, treatment, and criminal justice services; and (3) the quality and cost effectiveness of substance abuse services administered by state agencies and the Judicial Department.

It was further recommended the secretary of the Office of Policy and Management shall establish a central repository of substance abuse data that can be accessed by contributing state agencies, the Judicial Department, and General Assembly for aggregate analytical purposes. The secretary shall also submit an annual report to the General Assembly, Judicial Department, and state agencies that summarizes, but is not limited to: (1) client and patient demographic information; (2) trends in illegal drug use and other risk

factors associated with substance abuse; (3) effectiveness of services based on outcome measures; and (4) a statewide costs analysis.

The committee believes a better understanding of the illegal drug problem is integral to effective policy development. This recommendation is a necessary first step to changing the current course of the substance abuse policy. Data and trend analysis will provide the necessary foundation. So, while there is consensus among agencies that it is important to understand the "big picture" of the system's effectiveness, accessability, and costs, current data collection efforts and evaluation mechanisms do not accommodate this need.

The responsibility is placed within the Office of Policy and Management (OPM) for several reasons. OPM is statutorily mandated to assist the governor in the formulation of policy and the state budget: the state's final policy instrument. In addition, OPM has experience and expertise in overseeing statewide initiatives. A 1992 law (P.A. 92-123) required OPM establish a similar policy and procedure for evaluating and managing the quality and cost effectiveness of human service purchase contracts. Finally, other state agencies cannot sufficiently implement this recommendation because their primary responsibility is to provide services to meet its specific mandates and target populations. Conflict will ultimately arise when one agency's goals interfere with another's; in these situations, OPM with its responsibility for overall state policy can mediate a solution and forge interagency processes for policy development. Thus, as long as substance abuse is an issue that cuts across agency lines, OPM should serve as the gatekeeper and facilitator to ensure consistency in data collection and policy. OPM has already established a successful working relationship with the Judicial Department, which will provide information vital to the recommended database.

In addition, confidentiality issues relating to treatment and judicial data must be addressed. A key problem is federal confidentiality regulations covering DMHAS programs receiving funding from the federal Substance Abuse Prevention and Treatment Block Grant. The regulations contain such a restrictive "redisclosure" rule that DMHAS is impeded from sharing data with other state agencies on a confidential basis whose interest are strictly to evaluate outcomes for state public policy purposes. This is an untenable result as it bars the state from effective evaluation of a program that crosses state agency lines. OPM as the state's executive policy agency should be responsible for maintaining such data for research purposes only, and work with the affected agencies and the federal Health and Human Services to resolve the issue.

Currently, the state expended over $73 million (FY96) for addiction services through DMHAS, of which $55 million were general funds appropriations. The federal government contributes approximately $18.4 million (33 percent) in direct funds and block grants to this effort, which effectively confounds any comprehensive, effective outcome evaluation verifiable by agencies other than those directly involved in the services. Cost analysis becomes even more difficult in agencies other than DMHAS because of the difficulty in identifying direct and indirect

costs attributable to substance abuse treatment and other services, such as prevention and education.

Implementation of this recommendation should occur in two phases. First, OPM should review existing public and private data collection methods, outcome monitoring systems, and information technologies to determine similarities among available data, the best way to consolidate databases, and areas for new or more accurate data. Comprehensive analysis can then be conducted using the existing data and resources.

In the second phase a standardized assessment of drug use, substance abuse, and other relevant risk factors should be developed by OPM, in consultation with the Judicial Department. This should include a unique client identifier system. During this phase, OPM should require that executive branch policy directives, procedures, and funding requests relating to substance abuse services be based, to the extent possible, on performance data and outcome measures. Contributing state agencies can access the database through OPM and request specific aggregate analysis.

Policy Implementation

The administration of criminal justice and treatment can be criticized as a nonsystem.[13] As previously discussed, current state efforts to address substance abuse involve the many components comprising the criminal justice system. State agencies and community programs that provide treatment services are interdependent but each is a separate organization. Their work contributes to a sequence the relies on cooperation in meeting common goals and objectives of the state's substance abuse policies. However, each entity is independently operated, with its own sources of authority, lines of communication, accountability, and goals and objectives, all of which often are barriers to cooperation.

Case processing and management becomes more fragmented when the client is a child. The categorization of the child directs the services provided and the child is isolated within the agency responsible for addressing the most identifiable need -- delinquency, substance abuse, or abuse and neglect. Children found "delinquent" are tracked toward a correctional placement aimed at keeping them in a secure setting and modifying their behavior; few or no services address underlying family or social problems. Children with substance abuse problems may also be placed in residential settings but are usually provided services within their own community. Substance abuse treatment services are focused on reducing the use of drugs or alcohol and typically do not address the child's involvement in crime or family, school, or social problems. For abused, neglected, or abandoned children who are removed from their homes and placed in

[13]Dan Freed, *The Nonsystem of Criminal Justice: Law and Order Reconsidered*, (National Commission on the Causes and Prevention of Violence, Government Printing Office, Washington, D.C.), pp 265

foster care, the emphasis in on safety. While substance abuse and other services are offered to the parent(s) in an attempt to preserve or reunify the family, the child's needs may or may not be met.

Delinquent and substance abusing children have complex service needs and as a result might be found in the juvenile justice system, treatment system, mental health system, or the social welfare system. Within these systems, many state agencies and community-based programs provide a myriad of services, and without coordination children can drift in and out of all of them.

The program review committee found:

- *The overall system does not lend itself to a comprehensive response to young offenders or the problem of substance abuse. Except for the general goal of "prevent and control crime", there are no overall, interlocking objectives for the criminal justice, prevention, and treatment systems, especially when dealing with children and adolescents with substance abuse problems.*

To promote an integrated, comprehensive system, the program review committee recommended a Substance Abuse Policy Council shall be established. The council shall be comprised of commissioners or directors, or their designees, from the Judicial Department, state agencies responsible for providing criminal justice or substance abuse treatment, prevention, and education services, representatives from institutions of higher education such as researchers in the field, and representatives from state-funded, private sector provider organizations. The council shall be responsible for interpreting research and data analysis and reviewing policies and practices of individual agencies as they relate to the overall policy direction. The council shall report and make recommendations on substance abuse policy to the Office of Policy and Management and the committees of cognizance in the General Assembly. The Office of Policy and Management shall ensure a coordinated and comprehensive state substance abuse policy is developed.

The benefits of substance abuse treatment and intervention programs for young criminal offenders has been documented.[14] However, the lack of a comprehensive review and systemwide delivery system have resulted in a: failure to identify children's service needs; duplication of services; treatment program waiting lists or underutilization; and a lack of programs for certain populations, such as girls, pregnant women, older adolescents, and Hispanics. The program review committee believes this council would enhance interagency partnerships leading to more

[14]U.S. Department of Health and Human Services, *Preventing Adolescent Drug Use: From Theory to Practice* (1991) and U. S. Department of Justice Coordinating Council on Juvenile Justice and Delinquency Prevention, *Combating Violence and Delinquency: The National Juvenile Justice Action Plan* (March 1996) and *Guide for Implementing the Comprehensive Strategy for Serious, Violent, and Chronic Juvenile Offenders* (June 1995)

coordination and standardization. Further, the council would facilitate a dynamic approach to the direction of the existing substance abuse policy.

Representatives from the Judicial Department, Departments of Children and Families, Corrections, Education, Insurance, Mental Health and Addiction Services, Public Health, Public Safety, and Social Services, Division of Criminal Justice, Office of the Public Defender, higher education, governor's staff, legislators, and private treatment, social service, and business organizations participated on a substance abuse task force and policy council in 1996 to prepare recommendations addressing the social and economic costs of illegal drug use and addiction. The task force issued its report in February 1996 and went out of existence. The Alcohol and Drug Policy Council was then established by executive order, consisting of the same membership, to develop strategy to implement the Task Force's recommendations. The council was divided into five working subcommittees: criminal justice; youth and families; outcome monitoring; health care; and systems organization. It was recommended by the task force that the policy council remain active for a two-year period (throughout 1998) to oversee implementation of the recommendations. The task force and council were staffed by the Office of Policy and Management and Department of Mental Health and Addiction Services.

The task force has laid the groundwork for the recommended policy council. State agencies will maintain their authority to develop and implement policy and practices necessary in meeting their individual mandates. The committee believes creating this council will provide a better statewide perspective on the control and treatment of substance abuse and crime.

Juvenile Delinquency Issues

Since the early 1990s, some disturbing trends in drug use and crime by children and adolescents have emerged. Children are initiated to illegal drug and alcohol use at earlier ages. The rates in the use of marijuana have steadily increased although no where near the peak rates of the 1970s, and alcohol is still a predominant factor in juvenile delinquency and crime.

Research has shown that the rates of marijuana use and other drugs fluctuate, and there is some speculation among researchers and treatment professionals that the upward trend may not be the beginning of a dramatic surge in drug use. Use of illegal drugs and substances, other than marijuana, have not shown significant growth increases and, in fact, have remained fairly stable over the past several years.

At the same time, national statistics show that crime committed by children and adolescents is increasing and the level of violence is more serious. Generally accepted factors that contribute to the increased level of violence and crime are illegal drugs and the introduction of firearms to the juvenile population as part of drug trafficking. In Connecticut, the trend in arrests of young people charged with serious and violent crimes has remained constant; arrests for other

crimes, including drug offenses, has been increasing since 1992. There are insufficient data to draw conclusions about the incidences of violent crime, but the program review committee was told by criminal justice personnel and researchers that: children are using weapons and firearms more frequently; are becoming violent at earlier ages; are more often the victims of violent juvenile crime; and are increasingly involved in gangs. Adolescents have become more active in the drug trafficking business, which is traditionally violent due to the large financial rewards, its underworld nature, drug distribution turf wars, and the use of firearms to settle disputes and enforce street codes.

National research shows children and youth are involved in the sale of illegal drugs, like their adult counterparts, for two primary reasons: (1) to support their own use of drugs and alcohol; and (2) financial gain. Young people generally sell among their peer group. Profits are typically used for purchasing more drugs for sale and personal use as well as items like sneakers, clothing, and jewelry. It is important to note that, while their arrest may be for selling illegal drugs, most young offenders are primarily users in need of treatment services.

There is no single risk factor responsible for illegal drug use or juvenile delinquency and crime. Adolescents involved in these activities often have multiple risk factors in their backgrounds. Extensive research has identified those factors that make a child prone to drug use and criminal activity. They include: availability of drug and firearms in the community; community and family attitudes favorable toward drugs and crime; transition and mobility; poverty and community disorganization; family management problems and conflict; family history of drug use and crime; academic failure; lack of commitment to school; and friends engaged in drug use, delinquency, and crime. These factors tend to be cumulative and interact with one another resulting many times in serious drug use or criminal activity.

Through intervention, treatment, and other services, some risk factors can be reduced; others cannot. As discussed throughout this report, the criminal justice system has primarily been responsible for addressing the problems of juvenile drug use and crime. Recent legislation (P.A. 95-225) made significant changes to the juvenile justice system, emphasizing a "get tough" approach to children who commit crime. Law has been enacted that: (1) made it mandatory to transfer a child charged with a serious felony (class A and B) to adult court; (2) allowed access to juvenile criminal records to all relevant criminal justice agencies (previously the records were sealed); (3) created the serious juvenile repeat offender status allowing for sentencing in both adult and juvenile courts; and (4) added five new crimes, mostly weapons violations, to the list of serious juvenile offenses.

Existing law also includes mandatory sentences for drug offenses and increases the severity and length of the sentence with repeated convictions. For example, the statutory sentence for the first conviction of the illegal possession of narcotics, such as heroin, cocaine, or crack, is up to seven years incarceration, a $50,000 fine, or both. The length of incarceration

jumps to a maximum of 15 years for a second offense and up to 25 years for the third. As shown in the program review committee's earlier analysis, narcotic possession is one of the most frequently charged offenses among young offenders 14 through 20 years of age. Young offenders must be held accountable and swift, meaningful, and proportionate consequences should follow however, in practice, the options are often limited to reduced prison sentences or probation.

Another law restricts participation in diversionary options to first time offenders. Under the statutes, only an offender with no prior criminal history can use the accelerated rehabilitation program, youthful offender status, community service, and referral to a DMHAS drug treatment program. These programs also do not allow offenders charged with drug sale crimes to participate despite the probability they also use illegal drugs.

Within the population under analysis in the committee's study, the first-time offender charged with selling illegal drugs is typically a 16- or 17-year-old facing their first charge in adult court (although the offender may have a juvenile delinquency record.) Solely on the basis of the criminal charge of selling , the adolescent is ineligible for participation in any alternative sanction or treatment program.

Substance abuse is a chronic and progressive behavior and often a direct or indirect factor in criminal activity, especially in the sale of illegal drugs by young people. Given this, current state laws and practice relating to all first-time criminal offenders and offenders charged with drug sale crimes do not take into consideration the reality of drug use by children, adolescents, and young adults under 21 years of age.

In addition to these punitive measures, recent legislation established an alternative to incarceration program for juveniles. The Office of Alternative Sanctions (OAS) within the Judicial Department is mandated to develop programs to prevent and reduce delinquency and cooperate with existing agencies to provide services to juvenile offenders not requiring incarceration. The types of services provided include education, anger control, nonviolent conflict management, drug treatment, mental health treatment, and sexual offender treatment. The program is further required to provide early intervention services, including peer tutoring, community service programs, residential and social services, counseling, vocational training, and a mentor program. The alternative to incarceration program is not fully implemented at this time.

As previously discussed in Chapter III, another alternative is the drug court program that adjudicates criminal cases involving drug-dependent, nonviolent offenders and provides individualized justice. The drug court model is based on the theory of graduated sanctions.

There is consensus among the juvenile justice researchers that tougher laws and more punitive measures by themselves are not a panacea to reduce youth crime. Further, an effective

juvenile justice system is one that provides for graduated sanctions that allow for treatment, rehabilitation, education, and punishment. Reducing juvenile delinquency and crime requires coordination of services provided by criminal justice, treatment, child welfare, and education agencies as previously discussed, all options and alternatives must be administered in a coordinated manner and driven by a comprehensive policy.

The program review committee found:

- *Connecticut has established elements of a system of graduated sanctions but, based on past practice, they do not provide a coordinated approach to case management.*

- *Furthermore, existing law and judicial practice unnecessarily restrict certain types of offenders from programs that provide treatment and less punitive measures, hampering efforts at a graduated sanctions model.*

The program review committee recommended the Superior Court's pilot drug court program shall be expanded to all geographical area courts and include a juvenile docket for offenders between 14 and 16 years of age. The Judicial Department shall open the drug court program to all appropriate offenders with a documented substance use or abuse problem, except for those charged with violent class A and B felony crimes.

Furthermore, the statutory language concerning the accelerated rehabilitation, youthful offender, community service labor, and drug treatment programs that: (1) restricts participation to first-time offenders; and (2) excludes offenders charged with drug sale offenses shall be repealed. The Judicial Department shall have the authority to set offender eligibility criteria for participation and Superior Court judges shall continue to have discretion to grant participation in these programs.

In addition, for offenders under 21, the committee recommended the mandatory minimum sentences for drug offenses shall be repealed and the Judiciary Committee shall categorize drug offenses as classified or unclassified felonies or misdemeanors with appropriate sanctions.

Although specific data are not available for Connecticut, there is consensus among criminal justice professionals that treatment programs appear to be as or more effective than traditional incarceration. In addition, treatment programs are generally community-based, often costing significantly less than traditional sanctions.

As shown throughout the committee's analysis, substance abuse is a chronic problem requiring repeated or continuous treatment over a period of time. The statutory requirements that limit participation in diversionary programs to first-time offenders is self-defeating when the offender also has a drug use or abuse problem. An arresting or criminal charge should not be the sole factor excluding an offender from participation in an alternative sanction or substance abuse treatment program. The court, in exercising its discretionary authority, should have all options available before it to appropriately and effectively sentence an offender, especially an adolescent, and to determine if the community is adequately protected.

The Office of Juvenile Justice and Delinquency Prevention, with the United States Department of Justice, has defined the critical components of a successful graduated sanctions program for young offenders as:

- continuous case management;
- emphasis on reintegration and reentry to the community;
- opportunities for youth achievement and involvement in program decision making;
- clear and consistent consequences for misconduct;
- enriched educational and vocational programming; and
- a variety of forms of individual, group, and family counseling matched to youth's needs.

A graduated sanctions model moves juveniles and young offenders along a continuum of well-structured sanctions and programs that address both the offenders' service needs and community safety. At each level of the continuum, the offenders are subject to more severe sanctions if they continue in their delinquent or criminal activity, including the use of drugs or alcohol. An underlying theory of graduated sanctions is youth are treated in the least restrictive setting, preferably while living with their families and remaining in the community. However, for public safety reasons, community-based treatment is not always appropriate, nor is family-based treatment when the family is dysfunctional or nonexistent. In these cases, the model provides for residential services and programs.

The program review committee believes the drug court model and the Judicial Department's alternative sanctions programs have the capacity to provide these necessary components. Especially, if a coordinated and comprehensive approach to criminal justice and substance abuse treatment policy is taken.

The committee further believes the drug court model can serve as a gatekeeper for all criminal offenders. A significant percentage of crime -- between 60 and 80 percent[15]-- is directly or indirectly drug-involved. A logical first step in the adjudication process, therefore, is an assessment or screening of the level of substance abuse and the need for treatment. The juvenile and adult probation units currently have an assessment policy in place.

The committee found during its case review, that the offender assessment practice does not follow policy. Assessment information was not available for a majority of the cases (about 70 percent in adult cases and 50 percent in juvenile.) The foundation for a systemwide assessment of offenders is in place, however, and can be incorporated into the drug court model.

[15]The percentage of crime that is drug-involved was derived from national, regional, and state data, anecdotal information from criminal justice professionals and substance abuse experts, and the committee staff's analysis of criminal justice and treatment data.

APPENDIX A
Glossary of Common Drugs, Narcotics, and Controlled Substances

Appendix A
Glossary of Common Drugs, Narcotics, and Controlled Substances

Drug	*Street Names*	*Status*	*Description*	*Effects and Reactions*
Amphetamines	Bennies, dexies, pep pills, speed, uppers, whites	Illegal	Stimulant	Sweating, headaches, blurred vision, dizziness, sleeplessness, anxiety, and user may become excitable, talkative, hostile, confused, and irrational. High doses can cause irregular heartbeat, loss of coordination, collapse, or a sudden increase in blood pressure that can result in very high fever or heart failure and death.
Barbiturates	Blues, barbs, downers, pinks, rainbows, reds, yellows	Illegal	Depressant	Effects are similar to those of alcohol: slurred speech; staggering walk; and loss of memory, and the user becomes irrational, unable to coordinate simple movements. Continued use requires increased dosage resulting in deep depression and often suicide. Very large doses, especially in combination with alcohol, can cause coma and death.
Cocaine	Coke, free base, nose candy, snow, rocks **Crack** is a particularly addictive form of cocaine.	Illegal	Strong stimulant	Produces a very short surge of energy and effects the central nervous system. Its effects include dilated pupils, elevated blood pressure, heart and respiratory problems, stuffy nose, insomnia, loss of appetite, hallucinations, paranoia, and seizures and after effects include depression, confusion, and being irrational. Use of cocaine can cause death by cardiac arrest.
Hallucinogens	Acid, adams, angel dust, buttons, LSD, M&Ms, mescal, PCP, pearly gates	Illegal	Mind altering	The most deadly of all drugs; none have any medical use. Very addictive, unstable drug causing extreme mental disorder, permanent brain damage, and life-long nightmares. Physical effects are: dialated pupils; elevated body tempature; increased heart rate and blood pressure; loss of appetite; sleeplessness; and tremors. The user may experience panic, confusion, suspicions, anxiety, and loss of control.
Heroin.	China-white, "H", junk, Mexican-brown, smack	Illegal	Narcotic depressant	By-product of the opium poppy with intoxicating effects that completely destroys the users ability to reason and produces a light-headed feeling often followed by drowsiness, nausea, vomiting, constricted pupils, watery eyes, and itching. Overdose may produce slow and shallow breathing, clammy skin, convulsions, coma, and possible death. Dependency is very likely.

Drug	*Street Names*	*Status*	*Description*	*Effects and Reactions*
Inhalants	gasoline, Krys, model glue, sprays, White Out	Illegal		Inhaling vapors results in disorientation, violent behavior, unconsciousness, or death. Negative effects include nausea, sneezing, coughing, nosebleeds, fatigue, lack of coordination, loss of appetite, decreased heart and respiratory rates. Long term use may result in hepatitis or brain and liver damage and can permanently damage central nervous system.
Marijuana	Grass, hash, jays, joints, pot, THC, weed	Illegal	Mind altering	Effects vary with dose & quantity but reduce short-term memory, comprehension, concentration, and coordination. Physical effects include exaggerated sight and sound, increase in heart rate, bloodshot eyes, dry mouth and throat, decrease in normal sexual development, and damage to lungs.

Source of Data: LPR&IC

APPENDIX B
Glossary of Terms

Glossary of Terms

Addiction: A state of habitual or compulsive use of alcohol or drugs.

Blood alcohol content level ("BAC"): Measurement of the level of alcohol in a person's bloodstream that is used to determine impairment and under the influence of alcohol. For adults and minors a BAC level of .10 percent or more constitutes under the influence. Between .07 percent and .10 percent is the impairment level for adults and .02 percent but less than .10 percent for minors.

Child: Any person under the age of 16.

Commitment: Placement of a child or youth in the custody of the Department of Children and Families by an order of the court.

Conditional discharge: Sentence that can be imposed for an offense other than a class A felony during which the offender is released from custody but subject to any conditions as the court may determine. Offenders are under the supervision of a probation officer.

Controlled drug: A drug: (1) containing any quantity of a substance listed in the federal Controlled Substance Act; (2) designated as a depressant or stimulant drug pursuant to federal food and drug laws; or (3) designated by the state commissioner of consumer protection as having a stimulant, depressant, or hallucinogenic effect and tendency to promote abuse or dependency. Controlled drugs are classified as: amphetamine; barbiturate; cocaine; cannabis; hallucinogenic; morphine; or stimulant or depressant types.

Concurrent sentences: The condition of the court that an offender adjudicated of more than one offense will serve each sentence at the same time, with the longest sentence controlling the length of incarceration.

Consecutive sentences: The condition of the court that an offender adjudicated of more than one offense will serve each sentence separately, with one sentence beginning after the other has been served.

Controlling sentence: The sentence imposed by the court for the most serious offense that is used by the Department of Correction in determining the length of incarceration.

Definite sentence: A sentencing structure that provides a statutory minimum and maximum range from which the court imposes a fixed sentence length. It is the statutory sentence structure in Connecticut.

Delinquent: A child who is found to have violated any federal or state law, municipal or local ordinance or order (other than one regulating behavior of a child in a Family With Service Needs) of the Superior Court.

Detention: State-operated or -designated facility to provide for the temporary care of a child who is alleged to be delinquent and who requires a physically restricted, secure environment.

Disposition: Orders of the court following adjudication relating to the most appropriate type of care and treatment of a child or youth, or sentencing following adjudication in the adult criminal court.

Drug abuse: The use of controlled substances solely for their stimulant, depressant, or hallucinogenic effect and not as therapy prescribed for medical treatment.

Drug dependency: A state of physical or psychic dependence, or both, upon a controlled substance through repeated periodic or continuous use. A person cannot be considered drug-dependent as a result of prescribed medical treatment.

Family With Service Needs: A family which includes a child who: (1) runs away without just cause; (2) is beyond the control of his or her parents or guardian; (3) has engaged in indecent or immoral conduct; and (4) is truant or habitually truant or continuously and overtly defiant of school rules and regulations.

Felony: A crime for which the sentence is greater than one year incarceration. Felony crimes are classified as A, B, C, and D, with A being the most serious.

Incapacitation: A state of impaired judgment as a result of the use of alcohol or drugs during which rational decisions cannot be made.

Intoxication: A state of impaired mental or physical functioning as a result of the use of alcohol or drugs.

Juvenile: Any person under the age of 16.

Mandatory sentence: A specific sentence length set out in statute that cannot be reduced by the court and must be served in full by a convicted offender.

Minor: Any person who is not of legal age. Generally, any person under 18 years and, for the purposes of possessing and purchasing alcohol, under 21 years.

Misdemeanor: A crime for which the sentence is one year or less.

Narcotic: A controlled substance including morphine, opium, opiates, cocaine, coca, and salts and derivatives having similar physiological effects and potential for abuse as a controlled drug.

Nolle Prosequi ("Nolle"): A decision by the prosecutor that a pending case may not be prosecuted. A case which has been "nolle" may be reopened within 13 months; if it is not reopened by then it is automatically dismissed.

Nolo contendere ("No contest"): A plea that is the equivalent to a guilty plea but protects the defendant from having an admission of guilt used against him or her in a civil court proceeding.

Parole: The conditional release of an inmate, under supervision of the Board of Parole, who has served part of the term for which he or she was sentenced to prison.

Plea bargain: The process of negotiation between the prosecutor and defense counsel aimed at reaching an agreed upon disposition of a criminal case. The prosecutor has the authority to reduce the criminal charge(s), dismiss or drop multiple charges, and make sentencing recommendations to the court.

Poly-drug use: The combined use of more than one drug or use of a drug and alcohol.

Probation: Placement of an adjudicated offender under the supervision of a state juvenile or adult probation officer and the rules of supervision set forth by the court.

Serious Juvenile Offender: A child who has been adjudicated by the juvenile court for a serious juvenile offense.

Serious Juvenile Offense: A violation of any one of several specific grievous criminal actions by a child, including murder, manslaughter, rape, kidnaping, arson, armed robbery, aggravated assault, and other acts designated in C.G.S. sec. 46b-120.

Split sentence: The practice of the court in imposing a definite sentence of incarceration and a subsequent fixed period of probation, usually between one to five years, to be served after the offender's release from prison.

Status offense: Any misbehavior of a juvenile that if committed by an adult would not be a crime, such as truancy and running away. Connecticut eliminated status offenses from law.

Young adult: Any person 19 to 20 years of age.

Youth: Any person 16 to 18 years of age.

APPENDIX C
Agency Response

STATE OF CONNECTICUT

OFFICE OF POLICY AND MANAGEMENT

February 5, 1997

Michael L. Nauer
Director
Legislative Program Review
and Investigations Committee
State Capitol, Room 506
Hartford, Connecticut 06106-1591

Dear Mr. Nauer:

I am pleased to respond to the Legislative Program Review and Investigations Committee's (LPRIC) final report on State Substance Abuse Policies for Juveniles and Youth.

Governor Rowland maintains a strong and consistent stand against substance abuse. As key elements of his 1995 Anti-Crime Initiative, the Governor advocated for additional resources for state and local drug law enforcement programs, State funding to add 100 new local police officers in our most crime ridden and drug plagued cities, and reform of the juvenile justice system. In his FY97 midterm budget adjustment, more than $6 million was earmarked to expand community based programs, with drug intervention and treatment components, for juvenile offenders. As well, he recommended State funding for the Fresh Start program, which places chronic drug using female inmates with children in a long term residential program. Funding support for school based anti-drug prevention programs has remained at a high level. Governor Rowland's anti-drug policies are clearly based on the belief that an effective battle against substance abuse must be waged on all fronts, including law enforcement, treatment, and prevention.

In order to improve our existing efforts and identify new ways to reduce substance abuse, the Governor created a bi-partisan Blue Ribbon Task Force on Substance Abuse in October 1995. The Task Force made 24 broad recommendations for action. The Governor subsequently acted upon one of the chief Blue Ribbon recommendations and established the Connecticut Alcohol and Drug Policy Council. The Council, co-chaired by Deputy Commissioner Thomas Kirk of the Department of Mental Health and Addiction Services and Brenda Sisco, Legislative Liaison to the Governor, is a 39 member panel representing State agencies, providers, the Legislature, academia, and private citizens. The Council has been meeting since August, and in a few weeks will publish its initial report, which will echo several themes found in your committee's report.

Phone: Fax:
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Common themes include:

- *Recognition that a balanced policy of enforcement, treatment, and prevention regarding youth and substance abuse is required; and*
- *The need for a comprehensive, coordinated statewide substance abuse policy and oversight body.*

The Legislative Program Review and Investigations Committee's second, third and fourth recommendations pertain to the lead role for substance abuse policy development in Connecticut. The Office of Policy and Management has been working closely with the Governor's Office and the Department of Mental Health and Addiction Services to provide leadership for the Connecticut Alcohol and Drug Policy Council. I share the Committee's interest in improving many aspects of the substance abuse service system through the development of uniform policies and procedures, data collection, and evaluation. At this point, I believe these goals are best achieved through OPM's continued leadership and collaboration with other agencies. This will maintain our focus on the development of policy initiatives which are subsequently implemented by line agencies, as appropriate.

Governor Rowland is committed to a forceful criminal justice response aimed at those who sell drugs, especially to youth. We therefore cannot fully support Recommendations #5 through #7 of your report. The upcoming Council report will recommend expanding the Drug Session in the New Haven Superior Court to additional locations, and establishing a pilot session for juvenile offenders, based on funding availability (LPRIC Recommendation #5). However, the recommendation to expand this non-conviction diversion option to serious offenders, including those charged with other than drug crimes, is inconsistent with the Governor's position of holding criminals accountable for their actions.

In addition, the Governor believes that restricting participation in the Accelerated Pretrial Rehabilitation, Youthful Offender and Community Service Labor programs to first time offenders, and not permitting those charged with drug sales to enter the programs, is entirely appropriate. We therefore do not support easing such limitations (LPRIC Recommendation #6). As well, Recommendation #7, which would repeal mandatory minimum sentences for drug offenses, would send the wrong message to purveyors of illegal drugs and undermine the public's confidence in our criminal justice system. However, for certain lower level offenses, the Governor continues to support alternatives to incarceration that provide meaningful sanctions, appropriate supervision, and related drug treatment services.

Thank you for the opportunity to comment on the Committee's report. I am confident that the combined efforts of the Alcohol and Drug Policy Council, the Legislative

Program Review and Investigations Committee, and the Law Revision Commission will result in real improvements in Connecticut's substance abuse enforcement, treatment and prevention systems. I can assure you that the Office of Policy and Management will remain a key partner in this important endeavor.

Sincerely,

FOR

Michael Kozlowski,
Secretary

STATE OF CONNECTICUT

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

February 4, 1997

Mr. Michael L. Nauer, Director
Legislative Program Review and Investigations Committee
State Capitol, Room 506
Hartford, Connecticut 06106-1591

Dear Mr. Nauer and Honorable Members of the Program Review Committee:

Thank you for your invitation to review and comment on the findings and recommendations of the Program Review and Investigations Committee's Report on State Substance Abuse Policies for Juveniles and Youth.

As the report accurately reflects, substance abuse is a complex, multi-faceted problem that requires the participation of many stakeholders in the public and private sectors to adequately address. Several state agencies in the Executive and Judicial branches apply significant resources to the problem as it applies to the populations they are charged to serve. The extent and complexity of the substance abuse problem presents a formidable challenge for providing a cost-effective, coordinated approach to reducing its impact on the citizens of Connecticut. Our state's enforcement and service delivery systems have a long history of providing high-quality, cost-effective services by experienced public and private providers who are dedicated to serving persons who are adversely affected by the use of alcohol and drugs.

In 1995, Governor Rowland convened the Blue Ribbon Task Force on Substance Abuse to identify ways to improve and build upon this system and to create new approaches to the problem. That work is well under way. I am pleased to see that the PR&I report supports and reflects a great many of the recommendations set forth by the Blue Ribbon Task Force on Substance Abuse in its 1996 report. The PR&I report will serve to reinforce the ongoing efforts to create better services for Connecticut.

I would like to offer the following comments, observations and corrections to the PR&I report.

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Mr. Michael L. Nauer, Director
Legislative Program Review and Investigations Committee
February 4, 1997

ISSUE:
THE PR&I REPORT STATES THAT CURRENT STATE DRUG POLICY IS A "TWO-PRONGED APPROACH" OF PUNISHMENT AND TREATMENT.

FACT:
Current state policy is actually three-pronged, including enforcement, treatment and PREVENTION. Prevention plays an enormous role in Connecticut for controlling use and abuse of alcohol and drugs, particularly among our youth. Connecticut's approach to prevention is recognized on the federal level as being best-practice and new federal resources have been awarded to Connecticut as a result of its outstanding quality.

ISSUE:
THE PR&I REPORT RECOMMENDS THE ESTABLISHMENT OF A SUBSTANCE ABUSE POLICY COUNCIL TO PROMOTE AN INTEGRATED, COMPREHENSIVE SUBSTANCE ABUSE SERVICE DELIVERY SYSTEM.

FACT:
There already exists a highly visible and fully operational Connecticut Alcohol and Drug Policy Council which is charged with developing ways to implement the recommendations of the Blue Ribbon Task Force, including promoting an integrated, coordinated system of prevention, treatment and enforcement. In August 1996, Governor Rowland issued an Executive Order establishing the CADPC which is co-chaired by a member of his staff and the DMHAS Deputy Commissioner of Addiction Services. Membership includes heads of executive and judicial branch state agencies that provide alcohol and drug related services, legislative committee chairpersons whose committees have cognizance over substance abuse issues, experts from leading academic and research institutions, private business, insurance and HMO's, medical and clinical experts in addictions, public and private community providers, and advocates. The CADPC organized itself in a manner to promote a balanced state policy of prevention, treatment and enforcement and a best-practice, outcome and data driven system by forming five committees: Systems, Outcomes, Criminal Justice, Youth and Families, and Primary Health Care. The CADPC began an intensive work schedule in early September and will continue to convene as a working body over the next two years. The initial report of the CADPC will be released in February with specific recommendations and a specific implementation plan.

SUGGESTION:
To avoid duplication and waste, no new council should be created. Rather, the work of the Connecticut Alcohol and Drug Policy Council should continue as planned.

Mr. Michael L. Nauer, Director
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February 4, 1997

ISSUE:
RECOMMENDATIONS 5 THROUGH 7 ADDRESS CRIMINAL JUSTICE AND ENFORCEMENT ISSUES AND RECOMMEND EXPANDING ELIGIBILITY FOR DIVERSION PROGRAMS AND REDUCING CERTAIN CRIMINAL PENALTIES.

FACT:
Effective drug and alcohol policy includes prevention, treatment and enforcement. Connecticut must sustain a clear message to its citizens, particularly to its youth, that use of illicit drugs and alcohol is harmful to individuals and to society as a whole and that persons who violate these drug and alcohol laws will be held accountable for their actions. At a time when studies indicate an increased use of alcohol and marijuana among Connecticut's youth, we must be especially emphatic that this message is consistently conveyed through all aspects of public policy.

ISSUE:
Report Observation
"FURTHERMORE, THE COMMITTEE FOUND THAT THERE IS NO SYSTEMATIC OR COORDINATED EFFORT TO MONITOR AND EVALUATE SUBSTANCE ABUSE SERVICES. STATE AGENCY AND JUDICIAL DEPARTMENT DATA COLLECTION EFFORTS IN THIS AREA ARE LACKING AND THE DATA THAT IS AVAILABLE IS INSUFFICIENT FOR A COMPLETE ANALYSIS. THE RESULT IS THAT THE GENERAL ASSEMBLY HAS NO EFFECTIVE MEANS TO DETERMINE AND VERIFY IF THERE ARE ANY BENEFITS DERIVED FROM APPROPRIATIONS AND EXPENDITURES FOR SUBSTANCE ABUSE TREATMENT PROGRAMS AND OTHER RELATED SERVICES." ***Executive Summary, page I***

FACT:
There has been an extraordinary emphasis by DMHAS over the last year to recognize, and reinvigorate where necessary, all statutes, procedures, and data sources that would contribute to informed policies and a well managed system. The following points are in order:

1. **JCAHO and HCFA Accreditation:** All state operated addiction service operations at Connecticut Valley Hospital and Blue Hills are monitored and evaluated per accreditation standards of the Joint Commission on Accreditation and Healthcare Organizations, generally accepted as the "gold standard." DMHAS, to maximize disproportionate share revenues (DSH), successfully had HCFA- certified all programs and staffing related to the detoxification and rehabilitation beds at these

facilities this past year. These service and monitoring standards are extraordinarily rigorous and continued adherence is reviewed by external monitors via periodic comprehensive site visits.

2. **Department of Public Health Licensing Visits:** All licensed addiction programs in the state, regardless of their source of funding, are reviewed by monitors from the Department of Health prior to renewal of their licenses. These are exhaustive, unannounced visits and lead to corrective action plans for any deficiencies. Indicative of the cooperative spirit between state agencies, the reports of these visits are forwarded to DMHAS by DPH. The latter has also offered to discuss the option of DMHAS monitors accompanying the DPH monitor at the time of the visit. As each emphasizes different aspects related to quality operations, this would not be duplicative.

3. **DMHAS Monitoring and Evaluation Procedures**: Per its regulations and procedures, DMHAS has extensive activities that are uniform and consistent over all programs that it funds. Some of these activities, e.g. collection and analysis of demographic and outcome measures, extend to licensed addictions programs it does not fund. A brief sampling of activities in effect is as follows:

   a.) **Onsite, unannounced and announced visits**, to all DMHAS funded programs in the state. Do note that almost all of these are the same ones that are partly funded by other state agencies or funding sources. DMHAS' review applies to all service and fiscal operations, **not just those clients or funds DMHAS is supporting**. These visits are often over a few days and lead to reports about all critical quality and operational aspects of the agency. Formal reports are drafted within fourteen (14) workdays, forwarded to the Executive Director and Board President of the agency, and include citations and required action plans for deficiencies. There have been 84 such reviews so far this fiscal year. The reviews include adolescent residential programs funded by DCF, DOC prison programs, hospital programs seeking Physician Emergency Commitment status, and the full range of community addiction services programs funded cooperatively by DMHAS, OAS, DOC, DSS, DPH, and by private sources.

   b.) **Outcome based contracts**, the specifics of which have been approved by OPM and the Office of the Attorney General, are in effect for all DMHAS-funded programs. Further, the programs complete admission and discharge data on all

of their cases, regardless of funding source, and these data include outcome measures. Since my tenure with DMHAS began in late 1995, these data have now been routinely compiled and analyzed, with refinements in the measures being implemented at this time. These contracts apply to prevention as well as treatment services.

c.) **Daily, Monthly and Quarterly Fiscal and Service Reports** are required in a variety of areas. Residential and detoxification censuses are now faxed to DMHAS from all of its funded programs by 10:30 a.m. each day. This monitoring of capacity will maximize access and efficiency of resource allocation and permits per unit cost analysis. Monthly reports of all services provided, beds used, and uniform admission and discharge data are submitted by all programs. Quarterly fiscal reports of all expenditures and revenues are submitted, again regardless of the source of the funds. Breakouts do reflect the different sources of state and other funding. Thus, cost per service type, per funding analysis, and per other variables are possible. Attached for your information are graphs representing comparison unit costs for all detoxification programs and intensive residential programs funded by DMHAS for FY 95. Understandably, this type of analysis is critical and is being increasingly used to "price" services we will purchase. Annual independent audits are also mandatory for all programs.

d.) **Prevention monitoring and evaluation** applies to all research and demonstration and other prevention programs funded by DMHAS. We invited a federally funded, independent team to audit Connecticut's prevention structure, standards, and so on and they submitted a highly favorable report. Their regard was such that Connecticut is being offered free consulting and technical assistance services for the next few years to create a true cross-state agency prevention plan and uniform prevention standards. The review team was particularly impressed with the state of the art prevention evaluation system DMHAS has had developed for it by the Pacific Institute of Research and Evaluation (PIRE). This prevention effort has extended across state agencies and throughout the full statewide Prevention Advisory Council DMHAS leads.

Given the above and other efforts, we believe it is clear that DMHAS has in place - and has aggressively accelerated - a comprehensive and uniform monitoring and evaluation process for substance abuse services.

Mr. Michael L. Nauer, Director
Legislative Program Review and Investigations Committee
February 4, 1997

ISSUE:
Report Observation
THE REPORT ALSO INCLUDES RECOMMENDATIONS FOR THE SECRETARY OF OPM TO ESTABLISH UNIFORM POLICIES AND PROCEDURES FOR DATA AND FOR EVALUATING DEMOGRAPHIC INFORMATION, USE OF SERVICES, QUALITY AND COST EFFECTIVENESS AND ANALYSIS. ***Executive Summary, page ii***

FACT:
We fully support the need for a comprehensive and well defined data system and will work with OPM and any other relevant agencies in the coordination. We also believe that such a system is already in place per statute that binds DMHAS and by actual implementation. Examples abound over the last year. Presentations I have given before the Committee, before the Alcohol and Drug Policy Council, and other forums include all of these data. Five members of the Committee were participants in briefing sessions I gave to regional legislative groups. The briefing provided treatment and prevention trends for each area as well as comparisons to statewide data. All legislators received this information. Social indicator studies, compiled based on results from several different state agencies, were included. Finally, as evident from the attached section entitled *"Responding to Substance Abuse in Connecticut"*, DMHAS is in a leadership role in collecting and analyzing a host of prevention and treatment data that is yielding a coherent, comprehensive system.

I sincerely hope that these comments and observations prove to be useful in adding clarity and understanding to those who read the report. I look forward to continued contact with you in order to reach our common goal of providing the best possible substance abuse service delivery system to the citizens of Connecticut.

Sincerely,

Thomas A. Kirk, Jr., Ph.D.
Deputy Commissioner for Addiction Services

attachments

cc: Dr. Solnit

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